



## **Evidence-Based Interventions for Youth with Behavioral Health and Substance Use Problems**

**A Report By The  
South Carolina Center of Excellence in Evidence-Based Intervention  
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## Introduction

The South Carolina Center of Excellence in Evidence-Based Intervention, created in January of 2016 and housed at the Institute for Families in Society, University of South Carolina, has been tasked with providing information to the Palmetto Coordinated System of Care (PSCS) Leadership Team regarding evidence-based intensive family service models, with the restriction that these models are included in the National Registry of Evidence-Based Programs and Practices (NREPP; Substance Abuse and Mental Health Administration). Therefore, this report does not represent an exhaustive or complete compendium of evidence-based family interventions.

Intensive family services are defined here as therapeutic interventions delivered to youth and their families in home or community settings to enhance social, emotional, and behavioral functioning and, importantly, to *prevent out-of-home placement* (i.e. into foster care, residential treatment settings, psychiatric hospital settings, juvenile justice facilities, or other group settings). Intensive family services can also be used to promote reunification after youth placement in an out of home setting.

Intensive family services are characterized by delivery in the home or community setting, around the clock availability of therapists, and the ability to provide crisis intervention. Sessions may occur multiple times per week; within these contacts providers may offer a range of therapeutic activities including individual or family therapy, crisis management, skills training, as well as service coordination and referral. A number of specific therapeutic techniques or strategies may be used to meet treatment goals. Importantly, flexibility in use of these strategies is necessary to serve the needs of an individual family; however, this flexibility must occur while maintaining fidelity to the intervention model being used.

In addition to information on intensive family services, information on select evidence-based family interventions as well as select evidence-based parenting or youth interventions that have been demonstrated to positively impact youth, parent, and/or family functioning are included in this report. This additional information is provided to support the goal of the PCSC to establish a continuum of care of services for youth and families. An array of intervention models are important to consider when building a system of care to meet the wide ranging needs of youth and families and to prevent later development of more serious behavioral health conditions.

This report is organized into three sections. The first section focuses on intensive family service programs that are designed to prevent out-of-home placement. The second section focuses on evidence-based family interventions that have been demonstrated to impact youth with substance abuse concerns and/or serious behavioral health conditions. The third section provides brief information on evidence-based parenting interventions as well as select interventions for specific

youth concerns. These latter interventions may be incorporated into more intensive service delivery models or used as stand-alone interventions in outpatient, home, or community settings.

The information used in this report has drawn heavily on the work of the PSCS work group that examined intensive family service models, the NREPP website ([www.samhsa.gov/nrepp](http://www.samhsa.gov/nrepp)), the California Evidence-Based Clearinghouse for Child Welfare website ([www.cebc4cw.org](http://www.cebc4cw.org)), the Blueprints Program for Healthy Youth Development website ([www.blueprintsprograms.com](http://www.blueprintsprograms.com)), program specific websites (provided here with program descriptions), research publications (included in the References section), as well as from direct discussions with program purveyors. A summary and recommendations section concludes this report.

## **Section One**

### **Evidence-Based Intensive Family Services**

Programs in this section represent evidence-based intensive family service models. These interventions are characterized by high-intensity service delivery with multiple client contacts per week and around the clock availability of therapists during treatment delivery. These programs are designed as family preservation models with the goal of preventing family dissolution and out of home placement of youth. These programs may also be considered for use upon youth return from an out of home placement. While these interventions are characterized by a manualized approach to treatment, therapists have flexibility in tailoring the intervention components to meet the needs of the families being served within the bounds of fidelity.

Given the level of intensity of services and the serious problems faced by youth requiring this level of service (e.g. serious behavioral health, conduct, and/or substance use problems, involvement in juvenile justice, mental health, or child welfare systems) each of these programs requires staff with advanced degrees in a mental health field, and intensive training for staff and supervisors.

Data collection in multiple forms is an integral part of intervention delivery and monitoring. This is often the most challenging aspect of implementation for community agencies, who may not be accustomed to routine collection of data to drive treatment decisions as well as to support continuous quality improvement. Thus, the intensive post-training implementation support offered by these programs is critical to maintain fidelity to the intervention models; only under such conditions can positive family outcomes and returns on investment be expected.

**Table 1: Intensive Family Services**

	Homebuilders	Family Centered Treatment (FCT)	Multisystemic Therapy (MST) Juvenile Offenders	Multisystemic Therapy (MST) Psychiatric Supports
Target Population	Youth ages birth to 17 at risk of out of home placement or returning from placement; involved in mental health, juvenile justice, or child welfare	Youth ages 13-17 at risk of out of home placement	Youth ages 12-17 with a serious behavioral problems and violent or chronic juvenile offenses	Youth ages 6-17 at risk of out of home placement due to serious behavioral problems and co-occurring mental health symptoms
Provider Qualifications	Master's degree; work in teams of 3-5 therapists and one supervisor.	Services delivered by a "certified therapist"; re-certification is required every 2 years	Operate as a team: 2 Master's level therapists with a doctoral level supervisor	Operate as a team: a doctoral level supervisor, 4 masters level therapists, one part-time psychiatrist and 1 bachelors level crisis caseworker
Training and Implementation	18-25 days of on-site training. Weekly phone consultations years 1&2; monthly thereafter. Biannual file and fidelity reviews	On site and online training available. Monthly technical assistance and licensure certification required	5-12 days on site training plus online webinars and workshops. Supervisors must attend an additional 2- day training. Significant post-training data and implementation support.	7 day on-site orientation training. Quarterly on-site booster trainings. 2 day supervisor orientation training. Significant post-training data and implementation support.
Cost estimates:	Initial costs for 2 trainers (30 people) is approximately \$65,000; annual costs are approximately \$20-25,000.	Per site, first year costs are approximately \$69,000; annual cost thereafter is approximately \$36,000.	For one team, initial year costs are approximately \$45,000; annual costs are approximately \$36,000.	For one team, initial year costs are approximately \$117,000; annual costs are approximately \$108,000.

## **HOMEBUILDERS**

**Program Website:** <http://www.institutefamily.org/>

### **What is the intervention and whom does it target?**

HOMEBUILDERS operates on a family preservation model of delivery and provides intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of out-of-home placement or those who have children that are returning from an out-of-home placement. Intervention goals include reducing maltreatment, family conflicts, and behavioral problems in a flexible, responsive manner. Drawing on social learning and crisis intervention theories, the program is structured to reduce barriers to family support services and maximize opportunities for family members to learn new personal and social skills. HOMEBUILDERS serves families with children birth to age 17 who are involved with the child welfare, juvenile justice, and/or mental health systems.

### **What does the intervention look like?**

- Given the urgency of situations that may result in out-of-home care, HOMEBUILDERS therapists respond immediately to referrals.
- Services are time-limited (4 to 6 weeks) with therapists on call 24/7. Each family receives an average of 40 to 50 hours of direct service; 2 booster sessions are offered in the 6 months after services end.
- Therapists carry only two 2 to 3 cases at a time and may use a range of research-based interventions, including crisis intervention, motivational interviewing, parent education, skill building, and cognitive/behavioral therapy. Therapists may also provide other services including psycho-education (e.g. communication skills training, anger management). Additional services may also be provided as necessary and appropriate to help clients meet basic needs or to teach skills to help the family function more effectively.

### **What outcome areas does the intervention impact?**

HOMEBUILDERS targets child behavior problems and out of home placements as primary outcomes. An early study (Kinney, Madsen, Fleming, & Haapala, 1977) found that 121 of 134 cases avoided out of home placement; at follow up approximately 3 months later 117 of 121 (97%) continued to avoid institutional placement. A more recent meta-analysis by the Washington State Institute for Public Policy in 2006 examining 14 research studies on intensive family preservation services found evidence for reductions in out-of-home placements for models that were determined to adhere to the Homebuilders model of intervention ("Intensive Family Preservation Services: Program Fidelity Influences Effectiveness—Revised - Full Report - 938, February, 2006). Additional outcomes include improvements in both externalizing and internalizing behavior problems in children.

## **What are key implementation issues to consider?**

A typical staffing pattern for HOMEBUILDERS is a team consisting of 3-5 therapists and one supervisor.

Training is provided by HOMEBUILDERS trainer, using one trainer for up to 15 participants or 2 trainers for up to 30 participants. Trainer fees are \$1250 per day plus travel expenses; training materials are \$120 per participant. HOMEBUILDERS Core Curriculum Training takes 5 days; approximately 13 additional 1-2 day trainings are provided to support therapists and supervisors in mastering a range of intervention techniques and topics, e.g. motivational interviewing, using cognitive and behavioral strategies, addressing domestic violence, working with parents with cognitive limitations (costs for materials for these additional trainings range from \$15 per participant to \$45 per participant depending on the topic).

HOMEBUILDERS includes mandatory training for supervisors as part of the process of building internal organizational capacity. Supervisor training takes an additional 4-8 days; on-site data manager training is also offered (1.5-2 days).

Significant post-training consultation and support is integral to developing organizational capacity to deliver the program. HOMEBUILDERS has a well-developed continuous quality enhancement system (called QUEST) consisting of training and a system of evaluation and feedback. Post-training, phone consultation is held weekly for 2 years, monthly in year 3, and quarterly thereafter for \$100 per hour. Site visits lasting 3-4 days also occur twice per year at \$1250 per day plus expenses for the trainer. File and fidelity reviews (twice per year) are \$100 per hour. Beyond these activities, technical assistance can be provided on an as-needed basis for \$100 per hour.

Access to the Online Data Manager (web-based information and data system) includes all assessment and treatment information. After an initial \$4900 activation fee, the annual cost of ongoing access to the Online Data Manager system is approximately \$5180 (this includes a monthly fee of \$350 and an annual \$980 upgrade fee).

## **Summary**

HOMEBUILDERS is one of the oldest and most well-established intensive family preservation programs that can serve families with children in the 0-17 age range who may be involved in a number of child-serving systems, including social services, mental health, and juvenile justice. Over 200 organizations within 23 states and six countries outside of the US (as of 2011) have adopted the HOMEBUILDERS model of intensive family preservation services. There is a strong and well-developed system for implementation, training, and quality assurance. The post-training support provided is significant. Organizations implementing HOMEBUILDERS would need to invest approximately \$24,000 for the first year for mandatory implementation support and approximately \$20,000 per year thereafter.

**Family Centered Treatment (FCT)**  
**Program Website: <http://www.ifcsinc.com>**

**What is the intervention and whom does it target?**

FCT is a family preservation program that focuses on building family-specific goals derived from a strengths-based perspective. The target population for Family Centered Treatment (FCT) are primarily youth ages 13 -17 at risk of out of home placement and who are involved in the juvenile justice system. While there are some indications of application beyond this population, inclusion in NREPP is based upon outcomes with this particular population.

**What does the intervention look like?**

FCT is provided by a certified therapist in the family's home or in other settings (e.g., school, workplace, home of a relative, community settings), with several hours of contact in multiple sessions each week, for an average of six months. However, the specific length of FCT is determined by the family's progress. FCT follows a four-phase model of intervention: Joining and Assessment Phase, Restructuring Phase, Valuing Changes Phase, and lastly, a Generalization Phase. A minimum of two multi-hour sessions occur per week and therapists are available for on call for the family during the intervention period, which lasts approximately 6 months.

**What outcome areas does the intervention impact?**

The key outcomes of studies using FCT have been diversion from residential treatment and recidivism. One recent pilot study of a brief version of FCT, Family Centered Brief Intensive Treatment (FC BIT) was located that was not included in the NREPP review in 2013. Study findings included positive impact on depression, hopelessness, and suicidality among 46 individuals ages 12-63 (10 of whom were under age 18) who qualified for hospitalization due to suicidal ideation (Anastasia, Humphries-Wadsworth, Pepper, & Pearson, 2015).

**What are key implementation issues to consider?**

Agencies wishing to implement FCT must be licensed through the Family Centered Treatment Foundation (FCTF), which provides the management, training, supervision, and data collection infrastructure to support FCT delivery. Maintenance of the FCT agency license requires monitored demonstration of fidelity to the four-phase model of intervention.

Before providing FCT, therapists must become certified via an online (100 hour) competency training course that also includes field-based competency requirements. Recertification is required every two years. Individual and peer supervision to support program delivery are intensive, taking approximately five hours per week.

The annual fee per site or organization for licensing is \$4,800. In addition, each site must undergo implementation readiness assessment and training for management staff (\$1,750 plus travel

expenses). On-site training for therapists and master trainers is required (\$20,000-\$28,000 plus travel expenses), as is specific supervisor training (\$9,500 plus travel expenses if the supervisor training is done face to face; it can be accomplished via web or phone conferencing).

Monthly technical assistance and licensure consultation is \$2,500-\$3,000 per site per quarter (\$10,000- \$12,000 annually per site), plus support for producing quarterly reports, monitoring fidelity and data outcome adherence (\$17,000-\$25,000 annually per site). The monthly technical assistance fee covers the mandatory therapist recertification process that occurs every two years.

## **Summary**

FCT has been adopted by organizations in nine states and research using this model is growing. The role of the family in determining goals and when treatment ends are important elements of FCT. The primary target population is youth involved in the juvenile justice system as that is the population with the strongest research evidence of impact. Applicability to youth with significant mental health and substance use concerns is not as well established at this time; however, research in this area is beginning to emerge.

**Multisystemic Therapy  
For Juvenile Offenders (MST)  
Program Website: <http://mstservices.com>**

**What is the intervention and whom does it target?**

MST for juvenile offenders is an intensive home and community based intervention designed to reduce antisocial behavior and other clinical problems for youth involved in the juvenile justice system for serious offenses. Thus, the typical target population is for youth ages 12-17 with a significant history of arrests. Youth with severe conduct problems or substance abuse may also be served using MST. (Youth with serious mental illness including psychosis, and who are suicidal or homicidal, are excluded).

**What does the intervention look like?**

MST is designed to be delivered in natural environments where influences on antisocial or problem behaviors occur: home, school, neighborhood, and the community. The goal of MST is to reduce antisocial behavior (delinquency and recidivism) and to prevent out of home placement. The intervention typically lasts approximately 4 months with therapists having frequent contact with the youth and family and being on call 24/7 during the intervention period. The intervention manual for MST is principle-based; thus, a wide range of specific intervention strategies may be used to help improve the daily functioning of youth and their caregivers.

**What outcome areas does the intervention impact?**

MST has been found to reduce re-arrests (recidivism), aggression and delinquent behavior, number of days of incarceration, and association with deviant peers. (Reduction in association with deviant peers is important as these associations are strongly linked to continued delinquent behavior). Reductions in substance use and improvement in family functioning have also been found (Henggeler, 1999, 2011).

**What are key implementation issues to consider?**

MST can only be implemented by licensed MST teams. Each MST team consists of 2-4 full time therapists, a half-time supervisor, and organizational support for service delivery. Each therapist can work with 4-6 families at a time. Weekly supervision occurs with both the on-site clinical supervisor and with a MST Consultant.

MST team members must be trained in MST and licensure includes an agreement to implement MST with full fidelity; quality assurance and outcome data are collected and reviewed by MST Services. Thus, delivering MST requires an ongoing contractual relationship with MST Services who provides direct support and oversight of the work of MST teams. Data on fidelity and outcomes are also collected by MST Services; data reports are generated that guide implementation and fidelity assessment.

## **Summary**

The evidence base for MST in reducing recidivism and out of home placement is strong. Importantly for South Carolina, there are currently three licensed MST teams in the state operating out of community mental health centers in Lexington, Greenville, and the Pee Dee. As of March, 2016 fourth MST team is being formed at the Beckman Mental Health Center (M. Swenson, MST Services, personal communication, 3/16/2016). Organizations must be prepared for substantial investments in both staff and training to maintain the necessary staffing pattern for the team. MST teams are dedicated to MST service provision and cannot be used for other types of interventions. There are significant ongoing requirements for direct supervision and involvement with MST Services in order to maintain team licensure, which includes providing MST services with fidelity and capturing the data required for ongoing quality assurance and outcome monitoring.

**MST With Psychiatric Supports  
(MST-Psychiatric)  
Program Website: <http://mstservices.com>**

**What is the intervention and whom does it target?**

MST-Psychiatric is primarily a family-centered intervention designed to treat youth ages 9-17 who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity. Substance abuse may be an additional co-occurring problem. The goal of MST-Psychiatric is to improve mental health symptoms, suicidal behaviors, and family relations and increasing time spent in natural settings such as home and school. MST-Psychiatric is based on MST for Juvenile Offenders and has its foundation in social-ecological and social learning systems theories. Given the population of interest are individuals with behavioral and mental health challenges, specific clinical and training components for staff are included in this version of MST. Specifically, these include addressing (1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness.

**What does the intervention look like?**

MST-Psychiatric teams intervene primarily at the family level to support and empower parents and caregivers with the skills and resources to effectively communicate with, monitor, and discipline their children. Barriers to effective parenting are addressed. The intervention assists parents and caregivers in engaging their children in pro social activities while disengaging them from deviant peers (as association with deviant peers is a specific risk factor for behavioral problems among youth).

The intervention is delivered in the family's natural environment (e.g., home, school, community) daily and when needed and for approximately 6 months.

**What areas does the intervention impact? How effective is the intervention?**

MST Psychiatric has been found in randomized studies to reduce the number of youth placed in hospitals, and the number of days hospitalized. Other important outcomes include increases in number of days the youth attended school, reductions in externalizing and internalizing behavioral symptoms, improvements in family function and family relationships, and decreases in suicidal ideation. However, the number of studies of MST-Psychiatric is small, especially as compared to MST for Juvenile Offenders.

**What are key implementation issues to consider?**

A MST-Psychiatric team consists of a full-time doctoral-level supervisor, four master's-level therapists, a part-time psychiatrist, and a bachelor's-level crisis caseworker. (These latter two positions augment

the type of team used with MST for juvenile offenders). Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provides an initial 5-day training, weekly consultation, and quarterly booster trainings.

## **Summary**

MST-Psychiatric benefits from the considerable implementation structures and supports developed for MST for Juvenile Offenders. Studies of MST-Psychiatric have included both males and females from a variety of backgrounds (Black or African American, White, Native Hawaiian or other Pacific Islander, and Asian). However, the empirical evidence supporting MST Psychiatric comes from a small number of studies; thus, MST Psychiatric is less well established than MST for Juvenile Offenders. According to MST Services, the organization responsible for MST training, dissemination, and support, this intervention research is considered foundational and additional sites interested in piloting this intervention are being sought (M. Swenson, personal communication, 3-25-16). Importantly, the staffing pattern requires access to a part-time psychiatrist to support the team. This can represent a significant barrier given the low numbers of child psychiatrists in South Carolina. Furthermore, the staffing pattern for the team is larger than that for MST for Juvenile Offenders, entailing greater costs. Lastly, as with MST for Juvenile Offenders, there are ongoing requirements for direct supervision and involvement with MST Services in order to maintain team licensure.

## **Section Two**

### **Evidence-Based Family Interventions**

This section details six separate evidence-based family interventions that are designed to serve youth with behavioral health, conduct, or substance use problems. Several of these models can serve transition age populations (e.g. youth 18-25 years of age). These services are typically provided on a weekly basis, can be provided at flexible times and locations, but do not offer the same level of intensity as the intensive family service models reviewed in Section One.

These family-based treatment models stress the critical importance of appropriate staff selection and training. Staff providing these services must be able to remain empathic, supportive, and non-judgmental.

Family-based interventions are particularly important for altering patterns of behavior that can increase the risk of exacerbating or maintaining problematic behaviors among youth. Delivery of such interventions requires dedicated therapists who can be flexible in meeting family needs but who can also maintain fidelity to the intervention model. Adherence is promoted by access to ongoing supervision; thus, supervisor training and dedicated support time is critical to intervention success. Each of these models works to alter problematic patterns of interaction among family members and to increase pro-social and positive behaviors among youth and families.

**Table 2: Evidence-Based Family Interventions**

	<b>Attachment Based Family Therapy (ABFT)</b>	<b>Adolescent Community Reinforcement Approach (A-CRA)</b>	<b>Brief Strategic Family Therapy (BSFT)</b>	<b>Family Behavior Therapy (FBT)</b>	<b>Functional Family Therapy (FFT)</b>	<b>Multidimensional Family Therapy (MDFT)</b>
<b>Target Population</b>	Youth ages 12-18 with major depressive disorder, suicidal ideation, and/or significant anxiety	Youth ages 12-22 with alcohol and/or substance abuse problems.	Youth 12-18 years old with substance abuse and other conduct problems	Youth ages 11-17 with mental health, substance abuse, or co-occurring disorders.	Youth and young adults ages 13-25 with substance abuse, delinquency, HIV risk behaviors, depression	Children and youth ages 6-17 with substance abuse, delinquency, and/or behavior problems
<b>Provider Qualifications</b>	Master's degree in a mental health discipline.	Minimum of bachelor's degree in a clinical field; master's degree preferred. Supervisors should have a Master's degree.	Master's degree in mental health field with at least 3 years of supervised clinical experience. Therapists must be recertified every 2 years.	Supervisors and providers must be state-licensed mental health professionals with therapeutic experience with the target population.	Therapists are required to be certified annually for the first 2 years, then biennially if they continue to meet certification standards.	Each site must have at least 2 full time master's level therapists and one part-time bachelor's level case manager.
<b>Training and Implementation</b>	3-6 days for on-site initial training. Followed by 60-90 minute biweekly group supervision phone calls.	3.5 day initial training; subsequent digital session reviews with clinicians and supervisors.	Teams of 5 therapists trained in phases: Phase 1 takes 6-9 months; Phases 2-4 focus on fidelity and last 12 months each; Phase 5 is 12 months, and includes recertification.	2 day on-site training workshop. 1 day on-site booster workshop. Half-day on-site consultation.	Sites must be certified to implement FFT. Training occurs in 3 phases taking approximately 3 years. Annual site certification required from the third year forward.	Training length not specified. Will be done on-site, via telephone and online. Annual 1-3 day on-site booster training.
<b>Cost</b>	Initial training: \$30-\$34,000 to train a team of 5 therapists	Approximately \$10-\$15,000 to train 20 people; annual costs thereafter are approximately \$9,000.	Per team, approximately \$66-\$69,000 for Phase 1; range from \$16,000 to \$5,000 in later phases	Developer contacted; no response to date.	Per site: Phase I approximately \$46,000; Phase II approximately \$20,000; Phase III approx. \$10,000	Initial training: \$4,500 per therapist and \$6,500 per supervisor. Annual booster training and recertification approximately \$3,000.

## **Attachment-Based Family Therapy (ABFT)**

**Program Website:** <http://www.facebook.com/Attachment.Based.Family.Therapy>

### **What is the intervention and whom does it target?**

Attachment-Based Family Therapy (ABFT) is a family therapy model specifically designed to target family and individual processes associated with adolescent suicide and depression. ABFT targets youth ages 12 to 18 years old.

### **What does the intervention look like?**

ABFT involves weekly sessions delivered over 12-16 weeks. ABFT is based on interpersonal theories of depression; in this model depression and suicide can be impacted by the quality of interpersonal relationships in families. ABFT is a trust-based, emotion-focused psychotherapy model that aims to repair interpersonal ruptures and rebuild an emotionally protective, secure-based parent-child relationship. Treatment is characterized by five treatment tasks: reframing the therapy to focus on interpersonal development, building alliance with the adolescent, building alliance with the parents, facilitating conversations to resolve attachment ruptures, and promoting autonomy and competency in the adolescent.

The ABFT model grows out of attachment theory and Structural Family Therapy tradition but is informed by more contemporary systemic approaches such as Multidimensional Family Therapy and Emotionally-focused therapy.

### **What outcome areas does the intervention impact?**

ABFT aims to repair the parent-adolescent attachment relationship and to rebuild trust. Studies have demonstrated improvements in clinical depression and reduction in suicidal ideation.

### **What are key implementation issues to consider?**

ABFT developers provide a starter packet giving detailed information about program requirements and criteria agencies can use to assess their implementation readiness. Training and certification occurs over a two-year period and consists of didactic work, video consultation with individual feedback, and group consultation. The treatment manual provides step-by-step guidance for therapists and supervisors for each of the therapy tasks in the model, and it describes the framework and rationale of the intervention, the session content, and the skills required for therapists in the treatment process. The introductory workshop uses a variety of teaching methods to present materials and engage participants. An advanced workshop, which provides ongoing support and additional skill development for therapists, is available. The therapist's adherence to and competency with the model are monitored through the supervisor's review of videotaped treatment sessions, which is followed by peer-to-peer supervision calls. There is a Web-based Behavioral Health Screen, an online assessment instrument, is accessed by clients at baseline and throughout treatment, and the data

collected are automatically provided to therapists for use in assessing treatment outcomes and maximizing the quality of program implementation.

**Summary**

ABFT is one of the few family-based models reviewed that may be helpful for adolescents who have depression and suicidal ideation as central to their presenting problems.

## **Adolescent Community Reinforcement Approach (A-CRA)**

**Program Website:** <http://www.robertjmeyersphd.com>

### **What is the intervention and whom does it target?**

The Adolescent Community Reinforcement Approach (A-CRA) is a behavioral intervention that focuses on prosocial activities and behaviors that support recovery. The program targets youth 12 to 22 years old with cannabis, alcohol and or other substance use disorders. The most unique element in A-CRA is that it involves parents/caregivers in the treatment program. Caregivers attend four sessions: two devoted to the caregiver(s) alone and two for the caregiver and the adolescent together. Among other things, the caregiver- alone sessions emphasize parenting “rules.”

### **What does the intervention look like?**

A-CRA is delivered in weekly sessions over an approximately 3-month period. The A-CRA Treatment Plan begins with the Happiness Scale; clients select areas from the Happiness Scale to work on. The Goals of Counseling form is then used to establish meaningful, objective goals in these areas and methods to achieve those goals. There are 17 procedures that therapists can choose to address with the adolescent, from problem-solving skills to pro-social activities. Functional analysis of substance use explores the antecedents and positive and negative consequences of a client’s substance use. This allows clinicians to identify new behaviors that will be reinforcing to the client while also discouraging alcohol and drug external triggers. Counseling Goals can include behavioral skills training, job skills training, social and recreational counseling, relapse prevention, and/or relationship counseling.

### **What are key implementation issues to consider?**

The A-CRA emphasizes the importance of observing an applicant’s skills as part of the hiring process through role-play; demonstration of empathic listening skills are important for clients seeking treatment in substance abuse.

Training is provided by the A-CRA developer, Robert J. Meyers, on site. Fees vary based on number of participants and would be approximately \$9,000 for the 2-1/2 day trainings plus travel expenses for up to 40 participants. Training materials are included and manuals are free. Ongoing feedback, coaching and post-training is also available; charges on average are approximately \$100 per hour. A detailed treatment manual is available that includes examples and tips to increase clinician competency as well as information on requisite clinician and supervisor qualifications. The training and coaching program is well developed and comprehensive.

A-CRA addresses fidelity through ongoing supervision by direct observation of sessions using audio or videotaping, and offering systematic feedback, plus positive reinforcement. Role-play is also used throughout the training process using a variety of clinical scenarios. Procedures checklists, audio review of sessions and written feedback, and certification requirements for supervisors and clinicians help ensure fidelity.

Additionally, the A-CRA has a web-based tool to facilitate the reviewing/certification processes. This allows clinicians upload their session recordings, and expert raters then access and review for continuous quality assurance.

### **Summary**

ACRA is currently being implemented in more than 30 sites across 14 states. Therapists trained in A-CRA have flexibility (built into the manual) for sequencing, spacing, number, and format for delivering treatment sessions. Therapists retain some autonomy during treatment sessions, as clinical skills are needed to make certain treatment decisions regarding tailoring the menu- driven approach to clients' individual needs. Use of direct session materials (e.g. recordings) in supervision is a strength of this program as it is the best method to assess adherence and fidelity.

**Brief Strategic Family Therapy (BSFT)**  
**Program Website: <http://bsft-av.com>**

**What is the intervention and whom does it target?**

BSFT is a structured, problem-focused family therapy program that targets youth ages 12 to 18 years old with moderate to severe behavior problems, including substance use. The goal is to decrease substance use and problem behaviors and to increase pro social behaviors. The intervention was originally developed through work with Hispanic/Latino families but has been applied to other populations.

**What does the intervention look like?**

BSFT is typically conducted in an average of 12-17 weekly sessions, depending on the severity of the problems. The intervention has four steps: organizing a counselor-family work team, diagnosing the nature of family strengths and problematic relationships, developing a treatment strategy, and implementing change strategies.

There are four key approaches in the BSFT treatment model: improving parent-child interactions, providing parent training/skills, developing conflict resolution and communication skills, and family therapy. The program is designed to support appropriate parental involvement and leadership, family communication, problem solving, clear rules and consequences, nurturing, and shared responsibility for family problems. In addition, the program provides specialized engagement strategies to bring resistant family members into therapy. Treatment plans are designed specifically for each family and are based on a structured diagnostic plan.

**What are key implementation issues to consider?**

The process for organizations begins with a 1-2 day Organizational Consultation Visit.

Training in BSFT is an intensive process leading to certification. The typical training cohort is 4-7 students and training proceeds in phases. Phase I is initial training and lasts approximately 6-9 months. The training program consists of both workshops and a supervised practicum during this time. Workshops cover essential BSFT elements including: theoretical concepts and foundation, relevant research findings, the diagnostic schema, treatment planning, and achieving systemic change. The BSFT Engagement Model for resistant families, and specifics for doing in-home BSFT, are also taught. The workshops address especially complex clinical dilemmas and allow time for therapists to practice essential skills.

Supervision leading to certification in BSFT begins 1-2 weeks after Workshop 1 and continues typically for 4-6 months (3 months is the minimum) depending on trainee progress. Supervision entails weekly phone/video reviews of the trainees' videotaped BSFT family therapy sessions, group feedback and consultation. Certification is awarded to trainees who complete the supervision stage and show competency in the mastery of BSFT principles.

Phases 2-5 are for maintenance and focus on fidelity monitoring. Yearly recertification is required to continue to practice BSFT for the first 3 years. Thereafter, recertification occurs every 2 years.

## **Summary**

A strength of the BSFT model is the focus on diverse populations. BSFT was originally developed with Hispanic/Latino families and has been subsequently tested with African American families. More recently, BSFT was selected by NIDA to be the adolescent treatment model to be tested as part of the National Clinical Trials Network (involving examining this model at 8 sites throughout the country with populations of all ethnic groups). The model has been used with a wide range of families including both intact and foster families as well as with deaf and/or hearing-impaired families.

## **Family Behavior Therapy (FBT)**

Website: [web.unlv.edu/labs/frs](http://web.unlv.edu/labs/frs)

### **What is the intervention and whom does it target?**

Family Behavior Therapy (FBT) is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth 11 to 18 years old.

### **What does the intervention look like?**

FBT derives from the Community Reinforcement Approach and includes strategies to enhance engagement and attendance. Participants attend therapy sessions with at least one significant other, typically a parent (if the participant is under 18). Treatment typically consists of 15 sessions over 6 months; sessions initially are 90 minutes weekly and gradually decrease to 60 minutes monthly as participants progress in therapy.

FBT includes several interventions including:

1. The use of behavioral contracting procedures to establish an environment that facilitates reinforcement for performance of behaviors that are associated with abstinence from drugs
2. Implementation of skill-based interventions to assist in spending less time with individuals and situations that involve drug use and other problem behaviors
3. Skills training to assist in decreasing urges to use drugs and other impulsive behavior problems
4. Communication skills training to assist in establishing social relationships with others who do not use substances and effectively avoiding substance abusers
5. Training for skills that are associated with getting a job and/or attending school.

### **What are key implementation issues to consider?**

FBT begins with an initial 2-day, on-site training. A follow up one-day on-site booster workshop is also provided. In order to support fidelity of implementation, there are annual case reviews, annual audiotape integrity checks, and a half-day, on-site consultation to review FBT clinic integration. FBT implementation materials include a manual for clinicians to facilitate treatment delivery and extensive implementation support is available. ( The manual is entitled "Family Behavior Therapy: A Step-by-Step Approach to Adolescent Substance Abuse" and includes CD-ROM with protocol checklists and program forms; \$48 each). There are a number of checklists, detailed documentation forms, and activity sheets available to provide implementation structure. Protocol adherence checklists, rating forms, and audiotape assessments are provided to support quality assurance.

### **Summary**

In comparison to the other evidence-based family interventions discussed in this report, less information is readily available regarding training and implementation, particularly costs of training.

**Functional Family Therapy (FFT)**  
Program Website: <http://www.fftinc.com>

**What is the intervention and whom does it target?**

The Functional Family Therapy (FFT) is a family-based prevention and intervention program for high-risk youth ages 11-18 that addresses delinquency, violence, substance use, or other behavior problems such as Conduct Disorder or Oppositional Defiant Disorder. Inclusion in NREPP is based on use of the intervention with adolescents ages 13-19 with substance abuse and delinquent or other high-risk behaviors. The intervention aims to strengthen family relationships and to reduce substance use and delinquent behavior.

**What does the intervention look like?**

Approximately 12-16 sessions are delivered over a period of 4-5 months. Sessions can be conducted in a clinical setting or in family homes.

The FFT intervention has five specific phases:

- Engagement: Concentration is on establishing and maintaining a strengths-based relationship with clients where the therapist demonstrates respect for all family members.
- Motivation: Relationship building and reducing the negative patterns that have developed within the family system where the therapist reiterates the positive and long lasting benefits of family therapy.
- Relational assessment: Focusing on how family members interact with one another on a functional level.
- Behavior change: Involves the implementation of various techniques to improve family relationships through communication, problem solving and avoiding substance use.
- Generalization: Emphasizes the consolidation and maintenance of new skills and behaviors, relapse prevention and community systems available to support both the family and recovering youth.

**What are key implementation issues to consider?**

Functional Family Therapy Site Certification is a 3-phase process and begins with sites submitting an application for site certification.

Phase I is clinical training and takes 12-18 months; the goal is for clinicians to demonstrate strong adherence and high competence in the FFT model.

Phase II takes 12 months and consists primarily of supervision training in order to support sites in being more self-sufficient while maintaining and enhancing site adherence and competence in the FFT model. The designated site supervisor will attend two two-day supervisor trainings, and is subsequently supported by FFT through monthly phone consultation and a web-based FFT supervision assessment system. One onsite training day is provided during Phase II; ongoing

consultation is provided as necessary. The site's FFT database is used to measure site/therapist adherence, service delivery trends and outcomes.

Phase III is a maintenance phase. The goal of the third phase is to assure ongoing model fidelity and staff development. FFT reviews the database for site/therapist adherence, service delivery trends and client outcomes. Continuing education is provided and all Phase III requirements are renewed annually. FFT oversight and consultation is considered necessary for a FFT site to remain certified.

FFT sites are responsible for training/consultation fees, costs to provide appropriate computer access to run the database, and costs related to administering assessment measures.

## **Summary**

FFT for Alcohol and Drug Abuse is the version of FFT reviewed by and included in the NREPP database and has been implemented at 14 different sites. However, the majority of information available for review on FFT was not specific to this particular variant of the intervention. The training process includes a distinct phase for supporting sites to become self-sufficient through development and support of a site supervisor. Additional variants of FFT continue to be developed, e.g. Functional Family Parole (Darnell & Schuler, 2015).

## **Multidimensional Family Therapy**

<http://www.mdft.org>

### **What is the intervention and whom does it target?**

Multidimensional family therapy (MDFT) is a family-based treatment developed for adolescents ages 11-18 with drug use and behavior problems. A multiple systems-oriented and developmentally focused therapy, MDFT targets the known areas of risk associated with adolescent drug abuse and delinquency and enhances those protective factors to promote successful adolescent and family development.

### **What does the intervention look like?**

Five assessment and intervention modules structure the MDFT approach, which takes from three to six months (12-16 sessions). Session frequency varies from at least one to three per week. Session content varies by stage of treatment. Treatment operates through three stages to build the foundation, address themes, and consolidate changes. Goals of MDFT include improving the parent-child relationship, interactions, and communication skills, supporting the parent's parenting practices and personal functioning, and improving communication between the family and other service systems they may be involved with.

### **What are key implementation issues to consider?**

MDFT is delivered by a team of at least two therapists with master's degrees in a clinical area (e.g. social work, marriage and family therapy, counseling). Sessions are recorded for supervision. Urine testing to monitor substance use. Full-time MDFT therapists providing home-based services will have caseloads of 6-10 families (depending on case severity); full-time MDFT therapists working in outpatient settings may have 10-20 on their caseloads. Supervisors need to have a master's degrees in a clinical field (e.g. social work, family therapy, counseling, psychology) and must be certified as an MDFT therapist. If an agency does not have an MDFT certified therapist to serve as supervisor, an individual within that agency will be designated and trained first as a therapist, then as a supervisor.

The MDFT model has been applied in a variety of community-based clinical settings targeting a range of populations. The parents of adolescents targeted in MDFT controlled studies have had a range of economic and educational levels. Adolescents treated in MDFT trials have ranged from high-risk early adolescents, to multi-problem, juvenile justice-involved, dually diagnosed female and male adolescent substance abusers.

### **Summary**

MDFT is being used in approximately 40 sites across 11 states. MDFT is also being examined in large research projects in Europe. By design, the MDFT approach is flexible and has been developed and tested in different forms or versions. Sessions may occur multiple times during the week, in a variety of contexts including the home or community settings.

### **Section Three**

#### **Evidence-Based Parenting and Youth Interventions**

In this section, a select range of evidence-based parenting and youth-directed interventions are described that can be considered for implementation in outpatient settings to address a range of behavioral health concerns among young children and adolescents. The interventions included here have substantial empirical support in terms of reducing children's social, emotional, and behavioral problems and have well-developed manuals and training procedures that support broad dissemination. All programs listed here are delivered by trained providers, typically at the master's level of education and above.

While a number of these interventions are currently in use in South Carolina by agencies and private providers, access to these interventions by families across the state is limited by the number and location of providers and agencies that offer these services.

Brief descriptions of these effective interventions are included in this report to increase awareness of interventions that can be applied with younger children or adolescents with emerging behavioral health problems to prevent escalation to more serious levels of impairment. Thus, these programs are important to consider when building a system of care to meet the behavioral health needs of children, youth, and families.

Importantly, there are a range of additional strategies and programs that may be helpful for families, including parenting or family support models that are not included in this review as these interventions are not specifically focused on child or youth behavioral health outcomes.

**Table 3: Evidence-based Parenting and Youth-directed Interventions**

	Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)	Incredible Years Series (IY)	Triple P-Positive Parenting Program (Level 4)	Parent Child Interaction Therapy (PCIT)	The 4 Rs and 4R's and 2 S's for Strengthening Families Program	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Target Population	Youth ages 3-17 in families at-risk for or with substantiated physical abuse	Children and youth ages 0-12.	Children and youth ages 0-12 with disruptive behaviors	Children ages 3-7 with disruptive behavior disorders	Youth ages 7-11 with disruptive behavior disorders	Children and youth ages 3-18 with a history of sexual abuse or exposure to trauma
Provider Qualifications	Master's degree or higher. CBT experience preferred.	Master's level clinicians	Master's level therapists preferred but not required	Certification needed. Must have masters degree or higher and be licensed as a mental health professional. May be a 4th year psychology doctoral student under supervision	Master's level clinician teamed with a parent advocate	Master's level or higher
Service Delivery	Family or group-based delivery	Group-based delivery	Family or group-based delivery	Family-based delivery	Group-based delivery	Family-based delivery

## **Combined Parent-Child Cognitive Behavioral Therapy**

CPT-CBT aims to improve parenting skills and to reduce child post-traumatic stress disorder symptoms and behavior problems through a structured treatment program of 16-20 individual or group therapy sessions. This program is for families of children ages 3-17 at risk for or who have a substantiated case of physical abuse. Sessions can last from 90 minutes (individual) to two hours (group). The intervention draws on elements of CBT as well as models for processing trauma.

## **Incredible Years Series (IY)**

The IY Series is designed to increase social and emotional competence and prevent, reduce, and treat behavioral and emotional problems in children up to twelve years of age. IY interventions are group-based interventions and include a parent training program, a child program, and a teacher training program. The child program consists of 45 minute sessions delivered twice weekly for consecutive years. Small group treatment is also provided in 2 hour sessions for 18-22 weeks. The parent training program consists of 2-3 hour sessions over the period of 12 to 20 weeks. The teacher training program includes 42 hours of monthly training delivered over the course of 6 days.

## **Triple P Positive Parenting Program (Level 4)**

Level 4 Triple P is a broad-based parent training skills curriculum for families whose children have multiple behavior challenges that are interfering with the child's functioning across home and school or community settings. Level 4 Triple P can be delivered in 10 sessions for an individual family, or in group-based sessions over an 8-week period. Using a self-regulatory framework, parents are taught a wide range of strategies for promoting desirable behavior and for managing misbehavior. Level 4 Triple P is one element of the Triple P System of Interventions, which has been demonstrated to improve outcomes related to child maltreatment when implemented at a population level (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009, 2016).

## **Parent-Child Interaction Therapy (PCIT)**

PCIT is a clinic-based therapy program for children 2-7 years old with conduct disorder. Parents are taught skill building and positive relationship strategies. The aim of the program is to increase the pro-social behaviors and strengthen family functioning. Therapy involves 2 phases of intense direct coaching which usually requires about 15 sessions. The first phase, Child-Directed Interaction, is focused on improving the parent-child relationship and attending to positive child behavior. The second phase, Parent-Directed Interaction focuses on providing parents with skills for managing misbehavior.

## **The 4 R's and 2 S's for Strengthening Families**

**4 R's: Rules, Responsibility, Relationships, Respectful communication. S's: Stress and Social Support**

The 4 R's and 2 S's for Strengthening Families is a 16 week multiple family group program designed to improve communication, promote learning, and reduce the mental illness stigma for children ages

7-11 with a diagnosed disruptive behavior disorder. Sessions are held in a group setting with six to eight families attending for one hour each week. Goals are met through interactive role-play and parenting skill building.

### **Trauma Focused CBT (TF-CBT)**

TF-CBT is designed to treat children and youth who are victims of sexual abuse or who have been exposed to trauma. This method is used to treat PTSD and related emotional and behavioral problems for youth ages 3-18. Both individual and parent-child sessions are central to this therapy. Parallel child and parent therapy sessions are given each week with psycho education, parenting skills, regulation strategies, and cognitive coping and processing being discussed. The program typically runs for 12-16 sessions, with one one-hour session each week.

## Summary and Recommendations

A number of considerations drive decisions regarding intervention selection. At the individual client and family level, treatment selection has historically been driven by this key question: “*What treatment works for whom under what conditions?*” This classic question has been posed for decades (e.g. Smith & Sechrest, 1991) and unfortunately cannot be answered with certainty. However, implementation science research makes it clear that many factors impact treatment outcomes and attention to these factors can increase the likelihood of obtaining desired outcomes. These include factors related to the intervention itself (quality of training and materials), factors operating at the level of clients, individual providers (e.g. attitudes toward clients and toward evidence-based interventions); organizations (e.g. culture and climate), and larger systemic factors including billing and reimbursement structures (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; Shapiro, Prinz, & Sanders, 2014). Thus, regardless of which intervention is selected for use, attention must be paid to examining the fit of the intervention with the providers, clients, organizations, and larger system.

The process of treatment selection begins with assessment of organizational factors such as readiness and fit for a specific intervention. Thus, it is important to note that even the “best” treatments may fail because they are not a good fit to the organization or to clients being served by that organization. In addition to the fit of the intervention with the organization, providers within the organization ideally need to have favorable attitudes toward evidence-based practices, and have a strong infrastructure to assure that they have the time and ability to implement the intervention. Access to supervision and support during training and implementation is critical to program success. Attention to delivering the selected intervention with fidelity is critical; this includes attention to the quality of the therapeutic alliance as this has been demonstrated to contribute independently to client outcomes (Norcross & Wampold, 2011). Adherence to standards for data collection to assess program impact, and use of the data to drive continuous quality improvement, is also necessary to provide high quality, effective services over time.

The recommendations below are made to support building an array of evidence-based services to address the behavioral health needs of youth and their families in South Carolina.

For youth in danger of out of home placement, HOMEBUILDERS should be considered for adoption at the statewide level as an intensive, crisis-oriented family preservation program. The history of the program, documented impact on out-of-home placements, and successful implementation in a large number of organizations in other states suggest this is a viable model. Specific to South Carolina, HOMEBUILDERS can be implemented with children and youth from early childhood through the adolescent age range who may be involved in the mental health, juvenile justice, or child welfare service system (or for those youth and families who are involved in multiple systems). Use of a common intervention for high need families being served by providers in multiple systems promotes consistency and cohesion among agencies and organizations, and can help establish a strong infrastructure for intervention. Furthermore, the strong implementation support provided by HOMEBUILDERS is important for sustained delivery of intensive family services.

Given that Multisystemic Therapy for Juvenile Offenders has teams that are currently operating at three mental health centers and a team is poised to operate at a fourth, full expansion of MST for Juvenile Offenders to include all CMHC catchment areas is also recommended. This will require a significant enhancement of infrastructure including the ability to attract and hire qualified candidates who can be successfully trained to deliver the intervention. While MST-Psychiatric offers good potential, the program is not at the same level of maturity as MST for Juvenile Offenders. Supporting at least one pilot intervention site for MST-Psychiatric in South Carolina may be considered for the future.

With regard to evidence-based family interventions, the choice of program rests on what the primary targets of the intervention are. For substance use, the Adolescent Community Reinforcement Approach (A-CRA) may be ideal and is currently being used within the South Carolina Department of Alcohol and Other Drug Abuse Services. When substance use is co-occurring with behavioral problems or delinquency, Functional Family Therapy has strong potential. A particularly helpful aspect of FFT is the focus of the model on training supervisors to promote site self-sufficiency. Development of internal organizational capacity is a critical element for lasting implementation. However, FFT is not currently being provided within the state.

The array of evidence-based parenting and youth interventions are provided for further consideration in building a system of care for South Carolina. A number of these interventions can be provided for families with young children whose social, emotional, or behavioral challenges are beginning to emerge. Having a range of high-quality, evidence-based interventions available to families when and where they need them is critical if we hope to reduce the number of youth and families who may need intensive family services. Importantly, interventions that are selected would ideally build on the evidence-based preventive interventions currently being implemented in South Carolina. For example, the Children's Trust of South Carolina is supporting the Strengthening Families Program and is in the early stages of supporting the Triple P-Positive Parenting Program. Parent-Child Interaction Therapy is available in at least three areas of South Carolina (Columbia, Charleston, and Beaufort). Importantly, as the emphasis by parents, providers, and policy-makers shifts toward evidence-based psychosocial treatment approaches, the availability of these interventions is expected to grow.

The South Carolina Center of Excellence for Evidence-Based Intervention is committed to working with the PSCS leadership team, South Carolina providers, and purveyors of evidence-based interventions to increasing availability of evidence-based interventions to support the ultimate aim of improving the behavioral health and well-being of children, youth, and families in South Carolina.

## Disclosure

Cheri Shapiro, Ph.D., is a training consultant for Triple P America, the entity responsible for dissemination of Triple P in the U.S.

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