# Evidence Based Practices for Adolescents with Disruptive Disorders

## Recommendations for CMHS Mental Health Block Grant Funds for Programs for Children or Adolescents with SED

**State Fiscal Year 2008**

(updated 3/8/07)

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<th>Overview</th>
<th>Functional Family Therapy (FFT)</th>
<th>Multisystemic Therapy (MST)</th>
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<td>FFT is an outcome-driven family intervention for adolescents who have demonstrated a range of maladaptive and disruptive behaviors.</td>
<td>MST is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. MST views individual behavior as determining and determined by a network of interconnected social systems (the family, the peer group, the school, the neighborhood). To successfully treat the juvenile offender, intervention may be necessary in any one or in a combination of these systems. MST views the parent(s) or guardian(s) as valuable resources, even when they have serious and multiple needs of their own.</td>
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| Reasons for Recommendation | 1) Functional Family Therapy is included in the following reviews of evidence-based practices:  
2) FFT staff have considerable experience with dissemination of FFT. | 2) Multisystemic Therapy is included in the following reviews of evidence-based practices:  
2) MST staff have considerable experience with dissemination of MST.  
3) Can be delivered by bachelor's level providers. |
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<td><strong>Diagnosis of Target Population</strong></td>
<td>ADHD, ODD, CD Has been used with adolescents referred from juvenile justice system and adolescents returning home following placement in residential setting.</td>
<td>CD, juvenile offenders, substance abuse</td>
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<td><strong>Age of Target Population</strong></td>
<td>11-18 years</td>
<td>10-17 years</td>
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<td><strong>Theory</strong></td>
<td>FFT emphasizes factors that research has found to enhance protective factors and reduce risk, including the risk of treatment termination. In order to accomplish these changes in the most effective manner, FFT is a phasic program with steps that build upon each other. FFT emphasizes the importance of assessment in understanding the ways in which behavioral problems function within family relationship systems. An on-going, multi-faceted assessment process is part of each phase of the FFT clinical model.</td>
<td>MST draws upon causal modeling studies of serious antisocial behavior. The primary theories guiding MST are social-ecological theory (Bronfenbrenner, 1979), and family systems theory (Haley, 1976, Minuchin, 1974). MST views youths as embedded within multiple interconnected systems, including the nuclear family, extended family, neighborhood, school, peer culture, and community. In assessing the major determinants of identified problems, the clinician considers the reciprocal and bi-directional nature of the influences between a youth and his or her family and social network as well as the indirect effects of more distal influences (e.g., parental workplace). For a treatment to be effective, the risk factors across these systems must be identified and addressed. Hence, the “ecological validity” of assessing and treating youth in the natural environment is emphasized under the assumption that favorable outcomes are more likely to be generalized and sustained when skills are practiced and learned where the youth and family actually live.</td>
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<td><strong>Key Service Activities</strong></td>
<td>The model consists of a systematic and multi-phase intervention map that provides a framework for clinical decisions, within which the therapist can adjust and adapt the goals of the phase to the individual needs of the family. The three intervention phases are as follows: <strong>Phase 1:</strong> Engagement and motivation <strong>Phase 2:</strong> Behavioral change <strong>Phase 3:</strong> Generalizations are sequentially linked to specific goals for each family interaction. The range of treatment is three to 30 sessions over a three-</td>
<td>Multisystemic Therapy (MST) is conducted by therapists who are part of a MST &quot;team.&quot; Two to four MST therapists and their on-site supervisor make up a MST team that works together for purposes of group and peer supervision, and to support the 24 hour/7 day/week on-call needs of the team's client families. MST therapists are full-time Master's-level or highly clinically-skilled Bachelor's-level mental health professionals. MST supervisors are typically assigned to the program a minimum of 50% time and may carry a small caseload if assigned full-time. MST supervisors are either doctoral-level</td>
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### Functional Family Therapy (FFT)

- A 3-month period, with a median of 12 sessions. FFT can be conducted in a clinic setting, as a home based model, or as a combination of clinic and home visits. FFT program implementation targets teams of up to eight clinicians who work together by regularly staffing cases, attending follow-up training, and participating in ongoing telephone supervision.

### Multisystemic Therapy (MST)

- MST staff must be highly accessible to their clients and often have both pagers and cellular phones. Typically MST programs budget for mileage reimbursement to cover 8,000 to 12,000 miles a year per therapist. Internet access for administrative staff is required for scoring of required Quality Control measures. It is recommended that a small amount of flexible funds be available to the MST team ($100 per client family) for occasional and/or emergency needs. An annual program-licensing fee is required and is based upon the size of the MST program.

### Primary Goals

**FFT**

- Improve communication and supportiveness within the family.
- Decrease intense negativity of family interactions.
- Increase use of positive solutions to family problems.
- Increase positive parenting strategies.
- Reduce adolescent's behavior problems.

**MST**

- Reduce criminal activity.
- Reduce other types of antisocial behavior such as drug abuse.
- Decrease incarceration and out-of-home placement.

### Manual

**FFT**

- Manual available through contact person listed.

**MST**

- Treatment manuals for antisocial behavior (Henggeler et al., 1998) and SED (Henggeler et al., 2002) are available from the Guilford Press via web site under **Product Order Form** link. All other manuals are only available to MST sites. All components of the quality assurance system are manualized.

### Treatment Setting

**FFT**

- In-home and/or clinic.

**MST**

- Home and community.

### Training/ Certification

**FFT**

- The training components involve: A 3-day clinical training for all FFT therapists in a working group; an externship training for one working group member (will become the clinical lead for the working group); 3 follow-up visits/year (2 days each on-site); and supervision consultations (4 hours of monthly phone consultation). FFT is also supported by a systematic assessment, tracking, and outcome assessment system. FFT site certification is a 3-phase process (individual

**MST**

- Training is designed for all clinical staff who engage in the treatment and/or clinical supervision of MST cases, as well as those in support and administrative roles for MST programs. Training in using the MST model is provided in three ways: (1) Five days of introductory training are provided for staff who will treat and/or clinically supervise MST cases; (2) Treatment teams and their clinical supervisors receive weekly telephone clinical consultation from trained MST experts; and (3) One- and one-half-day training "booster" sessions are
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<td>therapists are not certified). Phase 1 &amp; 2 are each a year long process. Phase 3 and annually thereafter is to assure ongoing model fidelity. FFT trains and certifies groups of 3-8 therapists.</td>
<td>provided quarterly.</td>
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<td><strong>Training Costs (estimated)</strong></td>
<td>In addition to the elements of clinical training, the package of program support and training services includes a pre-training site assessment, assistance with program specification and design (including the development of quality control and outcome tracking system), and ongoing assistance with overcoming barriers to achieving successful clinical outcomes. The cost of program support and training is based on an all-inclusive annual per team fee. Fees range from $15,000 to $24,000 per team, plus travel expenses based upon the nature and size of the program. Staff training in MST is an on-going process. A primary objective of MST Services is to assist organizations in building capacity to provide for part or all of their MST program's long-term training needs. In this context, program support and training expenses should be viewed as the annual cost of a Quality Assurance (QA) program. Based upon an average annual service capacity of 15 families per therapist per year, the total long-term QA costs (program support and training) is usually in the range of $400 to $550 per youth served.</td>
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<td>Implementation costs for Functional Family Therapy in one working group are approximately $29,500 for phase one and start-up costs (not including travel). The project cost, including training and implementation, is approximately $2,000 per family. Phase two training fees are $12,000 and Phase 3 training fees are $5,000 (not including travel).</td>
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<td><strong>Website</strong></td>
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<td>Holly deMaranville, Communications Coordinator Functional Family Therapy, LLC 1611 McGilvra Boulevard East Seattle, WA 98112 Phone: (206) 369-5894 Fax: (206) 664-6230 Email: <a href="mailto:hollyfft@comcast.net">hollyfft@comcast.net</a> Website: <a href="http://www.fftinc.com">www.fftinc.com</a></td>
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<td><strong>Research</strong></td>
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<td>Both randomized controlled trials and non-randomized</td>
<td>MST has resulted in favorable child and family outcomes in</td>
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<td>comparison group studies have demonstrated that FFT significantly reduces recidivism for a wide range of juvenile offense patterns Alexander, Pugh, Parsons, &amp; Sexton, 2000; Alexander, &amp; Sexton, 2002; Alexander, Waldon, &amp; Newberry, 1990; Gordon, Graves, &amp; Arbuthnot, 1995; Haas, Alexander, Mas, 1988; Hinton, Sheperis, &amp; Sims, 2003; Morris, Alexander, &amp; Waldron, 1988; Robbins, Turner, Alexander, &amp; Perez, 2003; Sexton &amp; Alexander, 2000; Skinner, Steinhauer, &amp; Sitarenios, 2000; Slesnick, &amp; Prestopnik, 2004; Wetchler, 1985). Compared with no treatment, other family therapy interventions, and traditional juvenile court services (e.g., probation), FFT can reduce adolescent re-arrests by 20–60 percent. In addition, studies have found that FFT dramatically reduces the cost of treatment. A recent Washington State study, for example, demonstrated savings of up to $14,000 per family (Aos, Barnoski, &amp; Lieb, 1998).</td>
<td>fourteen published randomized controlled trials. The approach has been empirically validated under circumstances that embody elements of efficacy research (randomized clinical trials, special training and monitoring of therapists, use of manuals) and effectiveness research (samples of youth with serious problems and characterized by few exclusion criteria; use of community-based practitioners) (Henggeler, Schoenwald, &amp; Pickrel, 1995; Hoagwood, Hibbs, Brent, &amp; Jensen, 1995; Kazdin &amp; Kendall, 1998).</td>
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### Outcomes: Symptoms

**POSIT:** The Problem Oriented Screening Instrument for Teenagers is a 139-item, self-report measure of potential problems in ten functional areas (i.e., drug use/abuse; mental health; physical health; family relations; peer relations; social skills; educational status; vocational status; leisure/recreation; aggressive behavior/delinquency), potentially in need of preventive, therapeutic or supportive services (McLaney, Del Boca, & Babor, 1994).

**Externalizing problems (CBCL)**
- Antisocial/violent behavior
- Drug use and drug-related arrests
- Criminal offending
- Substance use
- Psychiatric symptomatology
- Rearrests
- Days incarcerated
- School attendance

### Outcomes: Other

**FAMIII:** This self-report measure provides an operational definition of constructs included in the FFT model. The general scale focuses on the family from a systems perspective and provides an overall rating of family functioning. (Skinner, Steinhauer, & Sitarenios, 2000).

The OQ -45.2 is a brief 45-item self report outcome/tracking instrument designed for repeated measurement of client progress through the course of therapy and following

**Family and peer relations**
- Association with deviant peers
- Parent-child interactions
- Out-of-home placement
- Parent and adolescent's satisfaction with treatment
Functional Family Therapy (FFT)  
Multisystemic Therapy (MST)

| termination. The OQ³ is a standardized instrument with empirical support. It is based on normative data, and validity and reliability exceed industry standards. The OQ³ contains risk assessment items for suicide potential, substance abuse, and potential violence at work (Burlingame, et al., 1995). |

References for reviews of evidence-based practices


http://www.promisingpractices.net/default.asp

References for Functional Family Therapy


**References for Multisystemic Therapy**


