Evidence-Based & Promising Practice Models of In-Home Family Treatment in Connecticut



A Resource Guide for Families
& for Those Who Refer Families to Services

Wheeler
Innovative Care. Positive Change.

DCF CONNECTICUT

5-2020
12/17

Development of this resource guide was fully funded by the Connecticut Department of Children and Families (DCF) through use of funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) State Youth Treatment Planning Grant (Contract Number 1H79TI0260 35-01).

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MODEL	WHO IT IS FOR	SERVICE INTENSITY & DURATION	WHERE IT IS AVAILABLE	AGENCIES	HOW TO REFER
MDFT (Multi-Dimensional Family Therapy) mdft.org	Youth 9-18 and their families, requiring intensive level of intervention to address teen substance use disorders, substance misuse, serious misconduct/acting out behavior placing youth at risk of out-of-home placement	• 2-3 sessions/week • 4-6 months	Statewide	• Boys and Girls Village • Catholic Charities • Child and Family Agency of Southeastern CT • Child Guidance Center of Southern Connecticut • Community Health Resources • CT Renaissance • Connecticut Junior Republic • Family and Children's Aid • Hartford Behavioral Health • North American Family Institute • United Community & Family Services • The Village for Families and Children • Wheeler Clinic • Yale Child Study Center	• DCF worker • Probation Officer • Other treatment providers • Care Coordinators • Self-referral *(contact agency directly)* • Therapist in facility where youth is placed
MDFT-ATM MDFT Assert Treatment Model `aka: HYPE (Helping Youth & Parents Enter Recovery)`	Same as standard MDFT, with opioid use disorder, for ages 16-21	Same as standard MDFT, but adds Medically Assisted Treatment and Recovery Management Check Ups & Supports (RMCS) to extend for an additional 12 months.	Across CT	• Community Health Resources • Connecticut Junior Republic • United Community & Family Services • Wheeler Clinic	Same as standard MDFT

NOTE: "Statewide" indicates programs with widest geographic coverage for CT. "Across CT" indicates programs available in all regions, although some towns may not be covered. For specific coverage, contact the gatekeeper or provider for the program.

Rev. 5.20.20

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MST (Multisystemic Therapy) *(Standard MST)* mstservices.com	Youth 12-18 and their families; requiring intensive level of intervention to address severe misconduct/acting out behaviors and/or substance misuse, placing youth risk of out-of-home placement	• 3 sessions/week • 3-5 months	Statewide	• Child & Family Guidance Center of Greater Bridgeport • Connecticut Junior Republic • CT Renaissance • North American Family Institute • Wheeler Clinic	• DCF worker • Probation Officer • Other treatment providers • Care Coordinators • Self-referral *(contact agency directly)*
MST-PSB *(MST for Problem Sexual Behavior)* mstpsb.com	Teens 12-18 and their families; requiring intensive level of intervention to address teen problem sexual behavior (in addition to behaviors treated by standard MST)	• 3 -4 sessions/week • Average 7 months	Statewide	• Boys & Girls Village • North American Family Institute • Wheeler Clinic	• DCF worker • Probation Officer • Other treatment providers • Care Coordinators • Self-referral *(contact agency directly)*
MST-TAY *(MST for Transition Age Youth)* *Also known as MST-EA (MST for Emerging Adults)*	Older teens/young adults ages 17-20 with serious mental health concerns and/or, substance misuse, with recent court involvement or evidence of engaging in illegal activities; may need support to achieve/sustain independent living	• 3 -4 sessions/week with therapist as well as support from life skills coach • 6-9 months	Across CT	• North American Family Institute	• DCF worker • Probation Officer • Other treatment providers • Care Coordinators • Self-referral *(contact agency directly)*
MST-FIT *(Family Integrated Transitions)*	Teens 14-18 and their families, with history of serious misconduct and/or substance misuse who are returning to the community from incarceration or residential treatment where they have received Dialectical Behavior Therapy (DBT)	• 3+ sessions/week • Intervention starts 60 days before youth is released from placement, and for 4 months after youth returns home	Across CT	• Connecticut Junior Republic	• Probation Officer • Therapist in facility where youth is placed

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IICAPS (Intensive In-Home Child and Adolescent Psychiatric Services)	Children and adolescents (3-18) and their families, where youth is displaying serious emotional/psychiatric instability placing him/her at risk of psychiatric hospitalization	• At least 4-6 hours/week face-to-face contact with youth/family over 5-6 months (typically 3 sessions per week)	Statewide	• Boys and Girls Village • Bridges • Catholic Charities • Child and Family Agency of Southeastern CT • Community Child Guidance Clinic • Community Health Resources • Family & Children's Agency • Family and Children's Aid • Middlesex Hospital • Natchaug Hospital • Wellmore • Wheeler Clinic • Village for Families & Children • Yale Child Study Center	• Therapist from other program/setting • Hospitals • Schools • Probation Officer • DCF worker • Care coordinator • Self-referral *(call provider directly; must have insurance through Medicaid or some commercial insurance plans, or DCF involvement, including DCF voluntary services or self-pay)*
FFT (Functional Family Therapy) **fftllc.com**	11 – 18 year olds and their families with youth displaying acting out and other behavioral health concerns, /or substance misuse or substance use disorder (less intensive level of care need than MST, MDFT or IICAPS)	• 8-24 sessions, typically one time per week, over a 4-6 month period	Across CT	• Child Guidance Centre of Greater Bridgeport • Child & Family Agency • Community Health Resources • Wellmore	• Therapist from other program/setting • Probation Officer • DCF worker • Care coordinator • Self-referral *(contact agency directly)*
ACRA-ACC (Adolescent Community Reinforcement Approach – Assertive Continuing Care) aka: SSTRY	Youth 12-17 (18 will be considered on a case by case basis) with substance misuse or substance use disorders and their families (lower level of intervention intensity need than MDFT or MST) SSTRY extends to age 25	• ACRA typically one session per week, clinic-based, for 2-3 months • ACC in-home aftercare at least one hour per week, typically for three months	Across CT	• Child and Family Guidance Center (Region 1) • Children's Center of Hamden (Region 2) • Community Health Resources (Regions 3 and 4) • CT Junior Republic (Regions 5 and 6)	• Therapist from other program/setting • Probation Officer • DCF worker • Care coordinator • Self-referral *(contact agency directly)*

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Child First childfirst.org	Parents and their infants/ young children birth through age 6 who are: • showing early signs of emotional, behavioral or developmental difficulties • at-risk for the above due to exposure to trauma, significant stress or parental mental health difficulties	• 1-2 sessions per week typically 60-90 min each, for 6-12 months	Across CT	• Bridgeport Hospital • Child Guidance Center of Southern CT • Child Guidance Center Mid-Fairfield • Clifford Beers • Middlesex Hospital • United Communities and Family Services • The Village for Children and Families • Wellmore • Parent Child Resource Center • InterCommunity Inc • Family and Children's Aid • Charlotte Hungerford Hospital • Wheeler Clinic (Bristol/New Britain) • Child Guidance Clinic for Central CT	• DCF worker • Maternal Infant and Early Childhood Home Visiting program staff • Therapist from other program/setting • Care coordinator • Self-referral

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Parenting Support Services offers two intervention models: **Triple P - Positive Parenting Program** **Circle of Security**	For parents of children birth to 18 interested in strengthening parent-child relationships and learn positive parenting strategies to address a wide range of problem behaviors that may emerge at different stages of child development *(but not of severity to warrant other more intensive in-home treatments)* Model for parents of 6-18 year old Model for parents of infants up to age 6	• Services typically 60-90 minutes per week, for 4-6 months	Statewide	• Bristol Hospital • CREC • Catholic Charities • Child and Family Guidance Center • Child Guidance Clinic for Central CT • City of Bridgeport • CMHA • Community Health Center • Community Health Resources • ECHN • KIDSAFE • Exchange Club - S CT • Family & Children's Agency • Family Centered Services of CT • Family and Children's Aid • Hispanic Health Council • Kennedy Center • Klingberg Family Centers • Lower Naugatuck Valley PCRC • Madonna Place • McCall Foundation • Middlesex Hospital • St Francis • UCFS • United Services • Wellmore • Wheeler Clinic	• DCF referrals – go through DCF gatekeeper (DCF referrals have top priority) • Community or self-referrals (contact the Parenting Support Services program supervisor of the agency nearest you)

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MST-BSF (MST-Building Stronger Families) mstcan.com	Parents and their children, where there has been recent substantiated abuse/neglect of the children (within last 180 days) and evidence of parent substance misuse or substance use disorder. At least one child in the home is age 6-18. Addresses complex behavioral health needs of all family members.	• 3-4 sessions/week over 9 months	Towns served by DCF area offices of: • Manchester • Hartford • New Britain • Meriden • Waterbury • New Haven • Norwich	• CHR • Family Centered Services of CT • Wellmore • Wheeler Clinic	• Referral only from DCF through RRG substance use specialists
MST-IPV (MST for Intimate Partner Violence)	Same as for MST-BSF but with families that are struggling with intimate partner violence	Same	Towns served by the New Britain DCF Area Office	• Wheeler Clinic	• Referral only from DCF through RRG substance use specialists
FBR (Family Based Recovery)	Parent of infant birth to three with substance use disorder or recent substance misuse and DCF involvement; may have other co-occurring behavioral health concerns	• 3 sessions/week up to 12months	Across CT	• Child & Family Guidance Center • Community Health Resources • Community Mental Health Affiliates • Family Centered Services of CT • United Community & Family Services • Village for Children and Families • United Community & Family Services • Yale Child Study Center	• DCF primary referral source through RRG substance use specialists • Self-referral and community referrals accepted

Development of this training was fully funded by the Connecticut Department of Children and Families (DCF) through the use of funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) State Youth Treatment Planning Grant (Contract Number 1H79TI026035-01). Dissemination of the training is fully funded by the Connecticut Department of Children and Families through the use of funds from the SAMHSA State Youth Treatment Implementation Grant (Contract Number 1H79TI080188-01).

Developed by Elisabeth Cannata, Ph.D., Wheeler Clinic - 12/2017

multidimensional
FAMILY THERAPY

What is MDFT?

Multidimensional Family Therapy (MDFT) is an integrated, comprehensive, family-centered treatment for teens and young adults. MDFT simultaneously addresses substance use, delinquency, antisocial and aggressive behaviors, mental health disorders, and school problems. It improves parental and family functioning and prevents out-of-home placement. MDFT has been researched in over ten studies. Since 2001, MDFT has been implemented in over 150 programs in North American and Europe.

An Evidence-Based Practice

MDFT has demonstrated strong and consistent outcomes in 9 randomized controlled trials, the most rigorous test of intervention effectiveness. These studies have been conducted with diverse populations and settings in the United States and Europe by the model developer as well as independent researchers. The level of proven effectiveness for MDFT is unsurpassed.

MDFT is proven to DECREASE:

- Substance Use
- Crime & Delinquency
- Violence and Aggression
- Anxiety and Depression
- Out-of-Home Placement
- Sexual Health Risk

Proven to INCREASE

- School Attendance
- Academic Grades
- Family Functioning
- Pro-social Functioning
- Effective Parenting Practices
- Positive Peer Affiliation

Why choose MDFT?

- **Proven effectiveness**
  MDFT has over 30 years of supporting research in U.S.-based and international studies presenting significant and consistent clinical outcomes across 10 separate studies.
- **Rewarding for clinicians**
  MDFT receives high satisfaction ratings from clinicians and agencies. 85% of MDFT clinicians report that MDFT training gave them skills to be more effective therapists.
- **Fits well into existing clinical settings**
  MDFT can be tailored to any program. It has been integrated into substance abuse, mental health, juvenile justice, and child welfare sectors of care, and in outpatient, in-home, partial hospitalization, residential, drug court and detention/incarceration settings.
- **Learnable and sustainable**
  Since 2001, MDFT has been implemented in over 150 programs, 85% of which have been sustained. 95% of clinicians who start MDFT training complete it to certification.
- **Lowers service costs**
  MDFT costs significantly less than standard outpatient treatment delivered across the U.S. and is a third of the cost of residential treatment. It also saves costs by preventing out-of- home placements and the costs to the juvenile justice system of re-arrests/incarcerations.
- **Lowers training and implementation cost**
  Intial training and ongoing implementation and fidelity services provided by MDFT Interntional, Inc. is significantly lower than comparable programs.
- **Fosters agency autonomy**
  MDFT International, Inc. trains trainers in order to lower program costs, increase sustainability, and foster agency autonomy.
- **Puts families first**
  MDFT International, Inc.–the organization that promotes, trains, and certifies clinicians in MDFT treatment–is a 501(c)(3) public charity. Providing the best possible treatment for youth and families is our only priority.

How does it work?

Goals Within the 4 MDFT Domains

ADOLESCENT DOMAIN	• Improve self-awareness and enhance self-worth and confidence • Develop meaningful short-term and long-term life goals • Improve emotional regulation, coping, and problem-solving skills • Improve communication skills • Promote success in school/work • Promote pro-social peer relationships and activities • Reduce substance use, delinquency, and problem behaviors • Reduce and stabilize mental health symptoms
PARENT DOMAIN	• Strengthen parental teamwork • Improve parenting skills and practices • Enhance parents' individual functioning
FAMILY DOMAIN	• Improve family communication and problem-solving skills • Strengthen emotional attachment and connection among family members • Improve everyday functioning and organization of the family unit
COMMUNITY DOMAIN	• Improve family members' relationships with social systems such as school, court, legal system, workplace, and neighborhood • Build families' capacity to access and utilize needed resources

Best Practice Recognition

NREPP SAMHSA's National Registry of Evidence-based Programs and Practices

NIH National Institute on Drug Abuse

NIJ National Institute of Justice

UNODC United Nations Office on Drugs and Crime

OJJDP Office of Juvenile Justice and Delinquency Prevention

European Monitoring Centre for Drugs and Drug Addiction

AMERICAN PSYCHOLOGICAL ASSOCIATION

The California Evidence-Based Clearinghouse for Child Welfare

National Crime Prevention Centre
Centre nationale du prévention du crime

EARLY INTERVENTION FOUNDATION

Contact Us

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Follow us on Facebook, LinkedIn, or Twitter!

MST
Multisystemic Therapy

Multisystemic Therapy: How Is It Done?

Program Overview

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. The MST approach views individuals as being surrounded by a network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. In MST, this "ecology" of interconnected systems is viewed as the "client."

MST addresses the multiple factors known to be related to delinquency across the key settings, or systems, within which a youth lives. Using the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to facilitate positive change, the intervention strives to promote behavioral change in the youth's natural environment.

MST Goals and Treatment Techniques

The ultimate goals of MST are to provide parents with the skills and resources that they need to address independently the difficulties that arise when rearing teenagers and to give youth skills to cope with family, peer, school, and neighborhood problems. This is done, in part, by mobilizing individual, family, and community resources that support and maintain the long-term behavioral changes that occur during MST treatment. MST is a pragmatic, goal-oriented treatment program that targets factors in a youth's social network that contribute to his or her anti-social behavior. Thus, MST interventions typically aim to:

- improve caregiver discipline practices
- enhance family relations
- decrease a youth's association with deviant peers
- increase a youth's association with pro-social peers
- improve a youth's school or vocational performance
- engage youth in positive recreational outlets
- develop a natural support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes

Specific treatment techniques that facilitate these gains are integrated from therapies with the most empirical support, such as cognitive behavioral, behavioral, and pragmatic family therapies.

The Role of the Therapist and the Family

- MST is delivered in the natural environment (e.g., home, school, community). Family members help therapists to design the treatment plan, which ensures that it will be family-driven rather than therapist-driven.

- Therapists are responsible for engaging the family and other key participants in the youth's environment (e.g., teachers, school administrators, community members, workers from agencies with mandated involvement). Similarly, therapists and the provider agency are held accountable for achieving change and positive case outcomes.

- For MST therapists, treatment is an ongoing process of understanding the "fit" between identified problems and their broader systemic context. Therapists view each family member's behavior as "making sense" from that individual's perspective of the world. The therapist's job is to understand the "fit" of the targeted behavior and to devise strategies that help caregivers to address family members' needs.

- Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family to behave responsibly. Therapists emphasize the positive and use a family's or individual's strengths to bring about change.

- Interventions always target specific, well-defined problems, focus on present conditions, and are action-oriented.

- This "multisystemic" approach views individuals as being surrounded by a network of interconnected systems that encompass individual, family, and extrafamilial (peer, school) factors and recognizes that interventions may be necessary in any one or a combination of these systems to bring about a desired behavior change.

Continued on back >>>

Multisystemic Therapy:
How Is It Done?

<<< *Continued from front*

MST Service Delivery

- Therapists work with family members daily or weekly to achieve behavior changes that can be observed and measured. The effectiveness of these therapeutic efforts is evaluated continuously from multiple perspectives (e.g., caregivers, identified youth, school teachers, supervisor, MST consultant).

- MST uses a home-based model to deliver services. This helps to overcome barriers to accessing services, increases the likelihood that families will stay in treatment, provides families with intensive services (i.e., therapists are full-time staff who have low caseloads of four to six families per therapist), and helps to maintain treatment gains.

- MST treatment typically lasts approximately four months, with multiple therapist-family contacts occurring each week. Families usually see therapists less frequently as they get closer to being discharged from treatment.

MST Treatment Fidelity

Adherence to the MST treatment model is essential for positive results. MST has been proven to be a cost-effective program that reduces rearrests and out-of-home placements for chronic, violent, juvenile offenders. Research conducted on the effectiveness of MST has demonstrated consistently that strong adherence to the model is correlated with strong case outcomes, and poor adherence is associated with substantially poorer outcomes. Training, which is key to the success of the model, is intensive and ongoing. Clinical staff training includes a week of introductory and orientation training, weekly consultation with an expert in MST, weekly on-site clinical supervision for treatment teams and supervisors, and quarterly booster training.

Adherence is the primary focus of the weekly consultation process, and heavy emphasis is placed on establishing on-site supervision practices to ensure that therapists adhere to the MST program.

For Further Information

For more information about research-related issues: www.musc.edu/fsrc.

For more information about program development, dissemination, and training, contact:

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MST
Multisystemic Therapy

Note: This fact sheet was developed under a grant from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice (grant number 98-JN-FX-0015) to the Institute for Families in Society at the University of South Carolina. Points of view and opinions in this publication are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

MULTISYSTEMIC THERAPY – PROBLEM SEXUAL BEHAVIORS (MST-PSB)

MST-PSB is an ecologically oriented, family and community based treatment that has achieved promising long term outcomes for youth who have committed sexual offenses.

Target Population

- Male and female youth ages 10 – 17.4 years who have engaged in sexually offending behaviors
- May be returning from a residential facility or detention, or require an intensive program in order to assist them in remaining in the community
- Families willing to participate in the treatment which targets the problem sexual behaviors as well as other delinquent behaviors such as truancy and academic problems, aggressive behaviors, and substance use, that may increase the risk of the youth coming into contact with court authorities.

Referral and Service Initiation

- The team is available to accept referrals Monday-Friday, 52 weeks per year within the hours of operation.
- The team accepts referrals from its designated DCF Area Offices, their corresponding courts, and other community resources, following the referral process in the *Goals and Guidelines* (document that outlines the MST-PSB implementation processes developed by the provider and DCF regions served) noted for that team.
- When an adolescent and family are accepted for services, an initial intake interview will be conducted in the adolescent's home within 72 hours of the referral. The contractor will make allowances for meeting with families during evening hours and weekends. The contractor will assess the family's capacity and willingness to participate in MST-PSB treatment (i.e. willingness to provide informed consent, to ensure that at least one caregiver accepts that to some degree the problem sexual behavior did occur and to agree that a safety plan and monitoring are needed).

Caseload and Length of Service

Caseload = 4 per FTE clinician. The average length of service is 5 – 7 months.

The Contractor will provide:

- A minimum of 3 home visits per week.
- Services may be extended beyond this period for those cases that have been deemed clinically appropriate for extended service via consultation with the MST-PSB consultant.

Services and Interventions

- Structural and strategic family therapy
- Cognitive behavioral therapy
- Marital therapy
- Comprehensive risk assessment and safety planning
- Addressing any denial of the offending behaviors
- Indentifying and addressing the aspects of the youth's environment that contribute to both antisocial and problem sexual behaviors
- Assisting families to support youth in the development of social skills that will allow for the establishment of healthy peer relationships

Crisis Response

MST-PSB provides support to families in crisis on their active caseload 24-hours a day, 7 days a week, including weekends and holidays by an MST-PSB clinician who is on call. The team does not use local emergency mobile psychiatric services as common practice.

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MULTISYSTEMIC THERAPY FOR EMERGING ADULTS *MST-EA*

In CT also known as MST for Transition Aged Youth MST-TAY

MST-EA *or* MST-TAY

OVERVIEW

- Multisystemic Therapy for Emerging Adults (MST-EA) was designed for young people aged 17-26 at the highest risk for negative outcomes – those with multiple co-occurring problems and extensive systems involvement.
- MST-EA is an adaptation of standard MST, an evidence-based treatment with decades of research supporting its effectiveness with juvenile justice populations.
- MST-EA has been tested thus far with young adults with justice involvement and co-occurring behavioral health disorders (e.g., mood, anxiety, psychotic, trauma-related, and/or substance use disorders).
- Referrals have included juvenile and adult justice system-involved clients, youth aging out of foster care, prison re-entry populations, as well as young adults in supported housing programs.

GOALS OF MST-EA

- Develop an effective social network (a "family of choice") for adulthood
- Treat behavioral health conditions, including mood, anxiety, psychotic, trauma-related, and/or substance use disorders
- Target housing and independent living skills
- Target education and career goals
- Reduce interpersonal conflict and maintain client and social network safety
- Coordinate medical and psychiatric care
- If applicable, teach parenting skills

ROLE OF FAMILY & NATURAL SUPPORTS

- MST-EA clients can be living on their own, with family or friends, in foster care, or in group homes. Emerging adults are guided to identify their values and social network ("family of choice"), with those values guiding all elements of treatment and the social network being actively engaged.
- The emerging adult is the focus of MST-EA. Thus, family or caregiver involvement is not required. However, involvement of family or other supports is strongly recommended, and all efforts are made to identify such supports and include them in treatment.

TREATMENT DESCRIPTION

- The emerging adult collaborates with the therapist in designing the treatment plan that will be carried out over approximately 7-8 months (services generally range 6 to 12 months depending on client needs).
- Contact is multiple times per week in-person and by phone, and emerging adults are an active participant in each stage of treatment.
- Therapists are available 24/7 to emerging adults and their social network to address emergencies and remove barriers to treatment.
- MST-EA blends cognitive behavioral therapy, behavioral interventions, motivational interviewing, affective education, and extensive skill building to address the array of issues associated with the emerging adult's mental health symptoms, antisocial behavior, and other problems.
- MST-EA achieves its targets through changing how emerging adults function in their natural settings (home, school, community), leveraging the emerging adult's strengths, pulling in positive natural supports, and developing the emerging adult's skills and resources to overcome barriers to success.
- MST-EA also includes paraprofessional "Coaches" who help teach concrete life skills and engage clients in prosocial activities.
- In addition, psychiatric and physical health professionals are engaged by the MST-EA therapist to coordinate effective health care.

PUBLISHED OUTCOMES

Aside from the extensive data supporting standard MST for youth with antisocial behavior, support for MST-EA comes from an open trial conducted by the investigators and clinical data collected by the community-based MST-EA program. This NIH-funded work focused on evaluating MST-EA for young people with justice involvement and behavioral health conditions. Outcomes are summarized in two peer-reviewed publications[1,2] and demonstrate:

- Significant reductions in criminal charges and mental health symptoms
- Significant reductions in deviant peer involvement
- Reduced substance use
- Reduced placement in out-of-home settings
- Improved rates of employment

CONTACTS

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[1]Davis, M., Sheidow, A. J., & McCart, M. R. (2015). Reducing recidivism and symptoms in emerging adults with serious mental health conditions and justice system involvement. *Journal of Behavioral Health and Services Research, 42*, 172-190.

[2]Sheidow, A. J., McCart, M. R., & Davis, M. (in press). Multisystemic therapy for emerging adults (MST-EA) with serious mental illness and justice involvement. *Cognitive and Behavioral Practice.*

MULTISYSTEMIC THERAPY – FAMILY INTEGRATED TRANSITIONS (FIT)

FIT is an intensive, in-home model to help families of youth on parole to re-enter the community following an out of home placement.

Target Population

Youth who are DCF committed delinquents aged 12 - 17.5 year old (on parole) who are discharging from an out-of-home placement & returning home to live with a caregiver. Some 18 y/o's with approval from the supervisor & team consultant.

Referral and Service Initiation

- Referrals are made at a minimum of 90 days before the youth is to be discharged from the residential or CJTS (CT Juvenile Training School) placement.
- Referrals are made by the DCF Juvenile Justice Social Worker (JJSW) or the CJTS/residential clinician by sending a completed RAFT (MDFT-Reentry & Family Treatment)/FIT referral form and signed releases of information to Central Office. The referral documents are then sent to Wheeler Clinic, who determines which program (RAFT or FIT) better meets the needs of the youth.
- When a youth and family are accepted for services, an initial intake interview will be conducted in the child/adolescent's home within 48 hours of the referral, if services are to begin soon. If discharge is more than 90 days from the referral, a call is made to the JJSW to discuss the process when the discharge occurs.

Caseload and Length of Service

Caseload = 5 per FTE clinician. The average length of service begins two months prior to the youth being released from a juvenile incarceration facility and continues for a total of up to six months following release.

The Contractor will provide:

- a minimum of 3 home visits per week.
- FIT services can be extended up to one month if DCF parole, FIT program manager and the FIT QA consultant agree.

Services and Interventions

- The treatment approach is derived from Multisystemic Therapy (MST), which is a scientifically validated, cost-effective, and intensive family preservation model of community based treatment that addresses anti-social behavior in juvenile offenders.
- The FIT program adds a skill training component to MST, coaching parents to practice proven parent effectiveness skills, and coaching the whole family in emotion regulation skills, specifically skills derived from Dialectic Behavior Therapy (DBT) and Relapse Prevention.
- FIT incorporates principles of Motivational Enhancement Therapy (MET) to increase the motivation of youth and family to engage and remain in treatment and to reduce chemical dependency.

Crisis Response

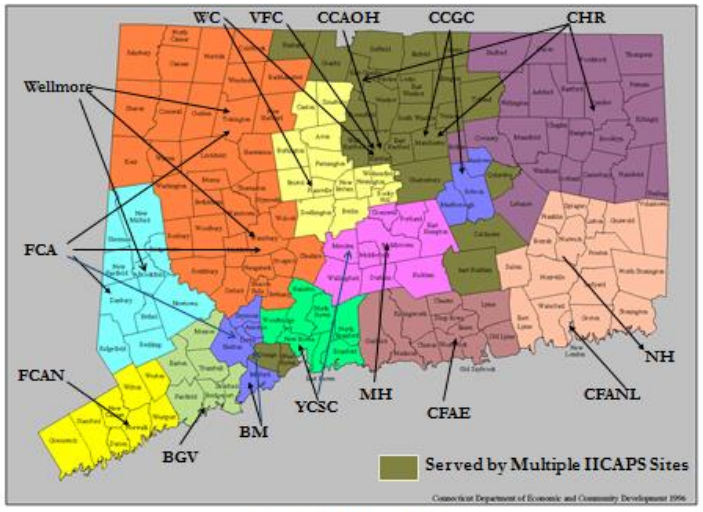
Support to families in crisis on their active caseload occurs 24 hours per day, seven days a week including weekends and holidays by a FIT clinician who is on call.

Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS)

IICAPS addresses the comprehensive needs of children with psychiatric disorders and their families to keep them safe in the home and community. Children appropriate for IICAPS are those who are discharged from psychiatric hospitals or residential treatment facilities children in acute psychiatric crisis for whom hospitalization is being considered; or children for whom traditional outpatient treatment is insufficient to maintain them in the community.

IICAPS provides intensive, home-based treatment to help families address the collaboratively identified *main problem* that places the child or teen at risk of repeat hospitalizations or out-of-home placement. The IICAPS team, the child and the family work collaboratively to identify and build upon strengths, to implement effective treatment strategies and to become effectively connected to resources and supports that will help maintain stability.

IICAPS was developed and studied by the Yale Child Study Center in New Haven, CT. Yale provides IICAPS training, certification and ongoing quality assurance to agencies in the IICAPS Network throughout Connecticut:



IICAPS PROGRAMS IN CT

IICAPS Programs:

- Boys and Girls Village (BGV)
- Bridges (BM)
- Catholic Charities (CCAOH)
- Child & Family Agency of Southeastern CT CFANL)
- Community Child Guidance Clinic (CCGC)
- Community Health Resources (CHR)
- Family & Children's Agency (FCAN)
- Family and Children's Aid (FCA)
- Middlesex Hospital (MH)
- Natchaug (NH)
- Wellmore
- Wheeler Clinic (WC)
- Village for Families & Children (VFC)
- Yale Child Study Center (YCSC)

FUNCTIONAL FAMILY THERAPY (FFT)

Clinical Model

FFT is a short-term, high quality intervention program with an average of 12 to 14 sessions over three to five months. FFT works primarily with 11- to 18-year-old youth who have been referred for behavioral or emotional problems by the juvenile justice, mental health, school or child welfare systems. Services are conducted in both clinic and home settings, and can also be provided schools, child welfare facilities, probation and parole offices/aftercare systems and mental health facilities.

FFT is a strength-based model built on a foundation of acceptance and respect. At its core is a focus on assessment and intervention to address risk and protective factors within and outside of the family that impact the adolescent and his or her adaptive development.

FFT consists of five major components: engagement, motivation, relational assessment, behavior change and generalization. Each of these components has its own goals, focus and intervention strategies and techniques.

Engagement

The goals of this phase involve enhancing family members' perceptions of therapist responsiveness and credibility. Therapists work hard to demonstrate a sincere desire to listen, help, respect and "match" to family members in a way that is sensitive and respectful of individual, family and cultural beliefs, perspectives and values. The therapist's focus is on immediate responsiveness to family needs and maintaining a strength-based relational focus. Activities include high availability, telephone outreach, appropriate language and dress, contact with as many family members as possible, "matching" and a respectful attitude.

Motivation

The goals of this phase include creating a positive motivational context by decreasing family hostility, conflict and blame, increasing hope and building balanced alliances with family members. Therapists work to change the meaning of family relationships by emphasizing possible hopeful alternatives, maintaining a nonjudgmental approach and conveying acceptance and sensitivity to diversity. The therapist's focus is on the relationship process, separating blame from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns, changing meaning through a strength-based relational focus, pointing process, sequencing and reframing of the themes by validating negative impact of behavior while introducing possible benign/ noble (but misguided) motives for behavior. The introduction of themes and sequences that imply a positive future are important activities of this phase.

Relational Assessment

The goal of this phase is to identify the patterns of interaction within the family to understand the relational "functions" or interpersonal payoffs for individual family members' behaviors. The therapist focuses on

eliciting and analyzing information pertaining to relational processes, and assess each dyad in the family using perception and understanding of relational processes. The focus is directed to intrafamily and extrafamily context and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, resources and limitations). Therapist activities involve observation, questioning, inferences regarding the functions of negative behaviors, and switching from an individual problem focus to a relational perspective. This sets the stage for planning in Behavior change and Generalization, where all interventions are matched to the families' relational functions.

Behavior Change

The goal of this phase is to reduce or eliminate referral problems by improving family functioning and individual skill development. Behavior Change often includes formal behavior change strategies that specifically address relevant family processes, individual skills or clinical domains (such as depression, truancy, substance use). Skills such as structuring, teaching, organizing and understanding behavioral assessment are required. Therapists focus on communication training, using technical aids, assigning tasks, and training in conflict resolution. Techniques and strategies often include evidence-based cognitive-behavioral strategies for addressing family functioning and referral problems. Phase activities are focused on modeling and prompting positive behavior, providing directives and information, developing creative programs to change behavior, all while remaining sensitive to family member abilities and interpersonal needs.

Generalization Phase

The primary goals in this phase are to extend the improvements made during Behavior Change into multiple areas and to plan for future challenges. This often involves extending positive family functioning into new situations or systems, planning for relapse prevention, and incorporating community systems into the treatment process (such as teachers, Probation Officers). Skills include a multisystemic/systems understanding and the ability to establish links, maintain energy, and provide outreach into community systems. The primary focus is on relationships between family members and multiple community systems. Generalization activities involve knowing the community, developing and maintain contacts, initiating clinical linkages, creating relapse prevention plans, and helping the family develop independence.

Alexander, J.A., Waldron, H.B., & Robbins, M.S., & Neeb, A. (2013). Functional Family Therapy for Adolescent Behavior Problems. American Psychological Association.

ADOLESCENT COMMUNITY REINFORCEMENT APPROACH ASSERTIVE CONTINUING CARE (ACRA-ACC)

ACRA-ACC is an evidence-based adolescent substance use treatment model which is delivered in a clinic, community, or home based setting to treat the unique needs of the substance using adolescent.

Target Population

ACRA-ACC is available to adolescents between the ages of 12-17 years, who meet both of the following admission criteria:

- has an identified substance use issue
- meets the American Society of Addiction Medicine (ASAM) criteria for an Outpatient level of care.

Eighteen (18) year olds may be admitted if they meet the exceptions criteria of living at home with their parents and/or caregivers, in addition to meeting the admission criteria above.

Referral and Service Initiation

Referrals are accepted from any source such as: the adolescent, a parent/caregiver, DCF, school, probation/court, police or community provider.

Caseload and Length of Service

Caseload = 12 per therapist

Length of service = 6 months

Crisis Response

The Contractors are expected to have in place a provision for on-call/after hour coverage.

Services and Interventions

EVALUATION

All adolescents referred to ACRA-ACC will receive a comprehensive evaluation, which will result in the formulation of a *DSM 5* diagnosis and an individualized treatment plan.

ACRA

ACRA's behavioral therapy uses social, recreational, familial, school or vocational reinforcers, and skill training so that non-substance using behaviors are rewarded and can replace substance use behavior. It uses a positive, non-confrontational approach, while emphasizing engagement in positive social activity, peer relationships, and improved family relationships. The intervention consists of a menu of nineteen procedures that are used and re-used as needed throughout the client's ACRA and ACC episodes. There are 3 types of ACRA sessions: adolescents alone, parents/caregivers alone, and adolescents and parents/caregivers together.

ACC is designed to follow a primary episode of treatment to help sustain recovery and uses ACRA procedures to structure sessions. In ACC, additional emphasis is placed on helping the adolescent follow-through with needed education/GED services, juvenile justice compliance, accessing healthcare, and other programs-social activities. ACC includes case management services and is delivered in the home and community setting.

DRUG TESTING

Drug tests are completed during the evaluation and randomly throughout treatment, at least monthly.

Reporting Expectations

- The Contractor will submit individual, client level data to the Department's PIE System or other system as required by the Department.
- The Contractor will submit data to the ACRA-ACC model developers and GAIN ABS, consistent with the requirements of the quality assurance process.
- If requested, the Contractor will provide written or verbal monthly progress reports to the referral sources concerning the youth they referred.

child first

Child First was evaluated with a randomized, controlled trial with strong positive outcomes. (Child Development, January/February 2011)

CHILD FIRST DEMONSTRATED:

68%
DECREASE IN CHILD LANGUAGE PROBLEMS

42%
DECREASE IN CHILD AGGRESSIVE AND DEFIANT BEHAVIORS

64%
DECREASE IN MATERNAL DEPRESSION OR MENTAL HEALTH PROBLEMS

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www.childfirst.org

Child First is an evidence-based, intensive, early childhood model that works with the most vulnerable young children and their families, helping them heal from the devastating effects of stress and trauma. Our two-generation approach builds strong, nurturing, caregiver-child relationships, promotes adult capacity, and connects families with needed services. This home-based intervention increases emotional health and learning success, and prevents child abuse and neglect.

The Challenge

Scientific research in brain development clearly shows that **high-risk environments** (e.g., where there is maternal depression, domestic violence, substance abuse, or homelessness) lead to levels of stress that can be **"toxic"** to the **young, developing brain.** Without the buffer of strong, nurturing relationships, the results are **long-term damage with significant emotional/behavioral, learning, and health problems.**

The Child First Response

Child First is an intensive, home-based model for children (prenatal through age five years) and their families, utilizing a professional team of a Master's level Mental Health/Developmental Clinician and a Care Coordinator. Key model components include:

1. **Psychotherapeutic, two-generation intervention,** which helps build a nurturing, responsive, parent-child relationship. This protects the child's developing brain from the damage of chronic stress, heals the effects of trauma and adversity for both child and parent, and promotes strong emotional health and cognitive growth.
2. **Care coordination** provides hands-on connection to broad community-based services and supports for all family members, leading to family stabilization, decreased stress, and utilization of growth-enhancing community resources.
3. **Facilitation of executive functioning** and self-regulation capacity is promoted for both parent and child, including memory, attention, planning, organization, and reflection.

Child First Accomplishments and Impact

- Child First has been designated as "evidence-based" by the federal HHS Maternal, Infant, and Early Childhood Home Visiting Program, Coalition for Evidence-Based Policy, National Registry for Effective Programs and Practices, and the Early Intervention Foundation.
- Child First now has 23 affiliates in North Carolina, Florida, and throughout Connecticut.
- Child First evaluation continues to show strong positive outcomes with 64% improvement in child language (large effect size), 53% improvement in behavioral problems (moderate effect size), and 65% improvement in caregiver depression (large effect size).
- Child First has been recognized by the Social Impact Exchange, Harvard Center on the Developing Child, Pew Home Visiting Campaign, Zero to Three, National Conference of State Legislators, and Connecticut and American Hospital Associations.

It's not perfect parenting...

It's Positive Parenting!

Each child, each family, each situation is different. How do you know what to do? **Parenting Support Services** takes the guesswork out of parenting. If you're dealing with any of these or more, we can help:

Babies 0-1yr	Toddlers 1-3yrs	Pre-schoolers 3-5yrs	School aged 5-12yrs	Pre-teen/teen 12-18yrs
• Crying • Sleep trouble • Bonding issues	• Tantrums • Hitting • Biting • Demanding behaviors	• Whining • Interrupting • Teasing • Defiance • Meal-time problems	• Talking back • Self-esteem • Anger • Chores • Sibling rivalry • Homework • School issues	• Risky behavior • Disrespect • Social problems • Isolation • Homework or school issues • Running away • Self-esteem • Stealing • Lying • Drug use

Parenting Support Services is a free, weekly, in-home service that will help you build confidence as a parent. You know your child best, so we won't tell you how to parent. We provide you with practical strategies to suit your family's needs.

We use tools and strategies from Triple P – Positive Parenting Program and Circle of Security – Parenting.

More information can be found at www.triplep-parenting.com and www.circleofsecurity.net

Parenting Support Services can help you:

- feel more confident and empowered as a parent
- enhance your relationship with your children
- provide a safe and engaging environment for your child
- improve your child's self-esteem, help them feel secure
- create realistic expectations
- find time to take care of yourself
- use positive discipline and effectively manage misbehavior
- raise stronger, more independent children
- help your child organize and make sense of their feelings
- reduce stress
- strengthen co-parenting skills

Organization name
Street, City, State Zip code
Other contact info

Organization Logo

Multisystemic Therapy – Building Stronger Families (MST-BSF)

Our Mission

The mission of MST-BSF is to keep families together, assure that children are safe, prevent abuse and neglect, eliminate parental substance misuse, reduce mental health difficulties experienced by adults and children, and increase natural social supports.

How the Program Works

Multisystemic Therapy - Building Stronger Families (MST-BSF) is an adaptation of Multisystemic Therapy (MST) that has been specifically designed to treat families who have come to the attention of child protection due to physical abuse and/or neglect and concerns about parents' substance use.

MST-BSF is administered to families in the home and at times convenient to the family. It is an intensive treatment involving a minimum of 3 sessions per week. All members of the family are involved in the treatment. Common treatment strategies include safety planning, Cognitive Behavioral Therapies for managing anger and addressing the impact of trauma, Reinforcement-Based Therapy for adult substance misuse, family therapy focused on communication and problem solving, and sessions to support the parent in taking responsibility for the events that brought the family to child protection.

MST-BSF is an intensive therapy, lasting six to nine months that addresses the specific problems that brought the family to child protective services plus important risk factors. The major goals of MST-BSF are to keep families together, assure that children are safe, prevent abuse and neglect, eliminate parental substance misuse, reduce mental health difficulties experienced by adults and children, and increase natural social supports.

Family-Based Recovery (FBR)

Family-Based Recovery (FBR) provides in-home attachment-based parent-child therapy and contingency management substance use disorder treatment. The mission of FBR is to ensure that substance affected children develop optimally in substance-free, safe and stable homes with their parent(s). FBR treats mothers and fathers who are actively using substances or who have recent history of substance use that are also parenting a child under the age of 3. Services are provided by a team of two clinicians and a family support specialist. The team provides individual, couples and family therapy; promotes positive parent-child interaction for secure attachment; works to increase a parent's awareness and understanding of child development; provides case management services and conducts weekly relapse prevention and parenting group. The program is funded by the State of Connecticut Department of Children and Families.

FBR Services, located at the Yale Child Study Center provides training, consultation and quality assurance oversight to programs offering FBR services throughout the state.

Agencies providing FBR:

- Child & Family Guidance Center
- Community Health Resources
- Community Mental Health Affiliates
- Family Centered Services of CT
- United Community & Family Services
- Village for Children and Families
- Yale Child Study Center