Best Practice- Washington State: Dialectical Behavior Therapy

**Background.** Dialectical Behavior Therapy was developed by Marsha Linehan to address issues specific to individuals with borderline personality disorder. Finding that traditional cognitive behavioral therapy often fell short of meeting the needs of patients with self-harm behaviors, she added techniques to balance acceptance with change.

**How does it work?** Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

**What was the development timeline?**
DBT treatment manuals were first published in 1993. Since then, it has been implemented in many therapeutic settings around the world and evaluated by independent, randomized clinical studies.

**How much did it cost?**
DBT training is available through private training companies, in graduate training programs at a number of universities, and through various professional associations (costs vary). Methods of training that have led to successful implementation involve an overview of DBT followed by intensive study and practice of the DBT concepts and strategies. The overview can be gained by study group review of the treatment manuals but is often enhanced by half-day or 1- or 2-day training and/or Web-based training. Behavioral Tech, LLC (http://behavioraltech.org/) offers in-person training at $125-$140 per day and Web-based training for $450-$550 per person, depending on duration of course access (1, 3, or 6 months). Other training options include graduate programs, a 10-day DBT intensive training ($2,400 per team member), and within-site training by a previously DBT-trained team member (at no cost). Full-scale system implementation trainings are available at a cost of about $21,000 per eight-member team.

**How was it measured?**
Suicide attempts were measured by the Parasuicide History Interview (now called the Suicide Attempt Self-Injury Interview, or SASII), a semistructured interview administered by blind assessors. Nonsuicidal self-injury (parasuicidal history) or NSSI was measured by blind assessors using the Parasuicide History Interview (now called the Suicide Attempt Self-Injury Interview, or SASII). Psychosocial adjustment was
measured using the Social Adjustment Scale and Longitudinal Interview Follow-Up Evaluation, Global Assessment Scale, Hamilton Rating Scale for Depression, State-Trait Anger Expression Inventory, and self-reports on targeted behaviors, among others. Drug use was measured by urine samples and structured clinical interviews. Symptoms of eating disorders were measured by the Eating Disorders Examination, and the Binge Eating Scale.

**What were the outcomes?**
After 1 year of care during a randomized controlled trial, 23.1% of DBT participants reported suicide attempts, compared with 46.7% of recipients of alternative expert treatment (p = .005). Multiple evaluations, including randomized controlled trials and independent studies, confirmed that patients completing 1 year of DBT experienced less nonsuicidal self-injury than patients awaiting care or receiving alternative treatment (p < .05). Seven randomized controlled trials found that 1 year of DBT improved at least some measures of psychological, social, or global adjustment, when compared with results for patients awaiting care or receiving alternative treatment (p < .05 across multiple measures). Two evaluations found sustained effects 16 and 18 months after treatment, respectively. In a randomized controlled trial, DBT participants were significantly more likely than alternative-treatment recipients to have drug-free urine screens 4 months after completing a year-long course of treatment; effect size was medium (Cohen's d = 0.75). DBT participants reported significantly less binging or purging behavior than patients awaiting treatment (p < .05). In one evaluation, 89% of DBT participants were free of purge behavior, compared with 12.5% of patients awaiting care (p < .001).

**What did you learn?**
DBT is an effective treatment for borderline personality disorder. At this point, the main difficulty is program fidelity, as there is no official licensure required to practice DBT. DBT has since been adapted for several specific populations. Evaluations of these adaptations are ongoing.

**Where can I find more information?**
http://www.behavioraltech.org
http://www.brtc.psych.washington.edu/

**Why is this a best practice?**
DBT has been shown to have a positive effect on mental health outcomes in numerous randomized clinical trials. In addition, its effect has bee replicated among diverse populations.
Best Practice- Washington State: Motivational Enhancement Therapy

**Background:** Motivational Enhancement Therapy (MET) is a systematic intervention based on principles of motivational psychology designed to evoke rapid, internally generated changes in behaviors of abusers of drugs and alcohol. It is a modified version of Motivational Interviewing, which was first developed as a “Drinker’s Check Up,” a follow-up to an assessment for problem drinkers. It has since been modified to treat a variety of problem behaviors.

**How does it work?** Motivational Enhancement Therapy (MET) is an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly nonconfrontational manner. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve their ambivalence and achieve lasting changes for a range of problematic behaviors. This intervention has been extensively tested in treatment evaluations of alcohol and other drug use/misuse. MET uses an empathic but directive approach in which the therapist provides feedback that is intended to strengthen and consolidate the client's commitment to change and promote a sense of self-efficacy. MET aims to elicit intrinsic motivation to change substance abuse by resolving client ambivalence, evoking self-motivational statements and commitment to change, and "rolling with resistance" (responding in a neutral way to the client's resistance to change rather than contradicting or correcting the client).

**What was the development timeline?** Motivational Enhancement Therapy and its precursor, the Drinker's Check-Up, have been implemented in well over 200 sites since 1985. Thousands of participants have received the MET intervention, which has been evaluated in approximately 30 separate research studies. Outside the United States, MET has been implemented in the Netherlands, New Zealand, Norway, and the United Kingdom.

**How much did it cost?** The cost per participant receiving MET is approximately $100. The costs of materials related to training and program implementation are minimal because they are in the public domain.

**How was it measured?** Substance use was defined as the self-reported number of days per week that the client used substances (marijuana, cocaine, alcohol, methamphetamine, benzodiazepines, opioids, or other drugs) using the Substance Use Calendar (SUC). Alcohol consumption was defined as the self-reported number of alcoholic drinks consumed per week by the study participant. The Drinker Profile structured interview employed by the investigators expresses participants' average weekly consumption in standard ethanol content (SEC) units. In one study, drinking intensity was defined as the number of drinks consumed per drinking day (DDD). The DDD measure was obtained through periodic interviews in which the client retrospectively examined his or her last month of drinking. These estimates of alcohol use were obtained by means of the Form 90 interview procedure that combines calendar memory cues within a Timeline Followback methodology. In other studies, weekly peak blood alcohol concentration
(BAC) was used as the measure of drinking severity/intensity. Using the Drinker Profile structured interview, estimates of weekly peak BAC were derived by computer projection to estimate the client's regular levels of intoxication. Marijuana use was defined as the number of times the client used marijuana on a typical day of use in the past 90 days. Clients reported their use on a 4-point scale: 0 = not at all; 1 = once; 2 = 2-3 times; 3 = 4-5 times; 4 = 6 or more times per day. Marijuana problems were measured with a 19-item list of negative psychological, social, occupational, and legal consequences of use. The list was adapted from other drug use severity indices in common use. Items on the list were rated on a 3-point scale ranging from 0 (no problem) to 2 (a serious problem).

**What are the outcomes?** MET and the counseling as usual (CAU) therapy sessions (three 50-minute sessions in each condition) both resulted in reductions in substance use during the 4-week therapy phase (p < .001). MET participants, however, sustained these reductions in substance use for the subsequent 12 weeks of follow-up, whereas CAU participants increased their use to their original, pretreatment levels. In another study, motivational interviewing with feedback was associated with greater reductions in client-reported alcohol consumption compared with a standard treatment approach (p < .001). Each of the studies reviewed clearly demonstrated that MET reduced the intensity of client drinking behavior over the course of outpatient treatment. With respect to treatment for marijuana use, participants in the MET group and the relapse prevention support group (RPSG) reported fewer days of use and number of times using marijuana per day compared with clients receiving delayed treatment. They also experienced fewer problems related to marijuana. These findings were observed at the 1-, 4-, 7-, 13-, and 16-month follow-ups when compared with pretreatment levels (p < .001 for all five follow-up points).

**What did you learn?** MET is an effective and efficient means of reducing alcohol and marijuana abuse. This program has multiple well-written and easy-to-follow manuals and instructional videos to support implementation. Many comprehensive training and support resources are readily available to interested implementers.

**Where can I get more information?**
http://motivationalinterview.org

**Why is this a best practice?** Motivational Enhancement Therapy is a best practice because it has shown positive and lasting results in several experimental studies that included a variety of ethnic groups.
Best Practice- Washington State: Motivational Interviewing

**Background:** Motivational Interviewing was initially developed to treat problem drinkers. It has since been expanded to address a variety of substance abuse issues as well as health promotion and medical treatment adherence.

**How does it work?** Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. The MI counseling style generally includes the following elements:

- Establishing rapport with the client and listening reflectively.
- Asking open-ended questions to explore the client's own motivations for change.
- Affirming the client's change-related statements and efforts.
- Eliciting recognition of the gap between current behavior and desired life goals.
- Asking permission before providing information or advice.
- Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the therapist to adjust the approach.)
- Encouraging the client's self-efficacy for change.
- Developing an action plan to which the client is willing to commit.

**What was the development timeline?** MI has been implemented extensively at hundreds of sites worldwide since 1983. Thousands of participants have received the brief MI intervention, which has been evaluated in at least 22 research studies for problem drinking alone.

**How much did it cost?** The cost per participant receiving MI is less than $75. The costs of materials related to training and program implementation are minimal because they are in the public domain.

**How was it measured?** Alcohol use was measured in a number of ways among randomized controlled studies. Some examples include measuring the number of standard drinks or standard ethanol content units (SECs) as defined in the Brief Drinker Profile (BDP), drinks consumed during the past 3 months, drinking days per week in the past 6 months, and average drinks per drinking day in the past 6 months. Other RCTs evaluating alcohol abuse used the Daily Drinking Questionnaire (DDQ) and the Adolescent Drinking Questionnaire (ADQ). Negative consequences/problems associated with alcohol use were identified using the Rutgers Alcohol Problem Inventory (RAPI) and the Alcohol Dependence Scale (ADS). In another RCT, negative consequences and problems associated with alcohol use were measured using 5 items from the Health Behavior Questionnaire (HBQ). Drinking and driving was measured using 5 items from the Young Adult Drinking and Driving Questionnaire. Moving violation records from the Department of Motor Vehicles were also examined for all licensed drivers in the study. Alcohol-related injuries were assessed using the Adolescent Injury Checklist.
(AIC), a 14-item, true/false, self-report measure of recent injuries, adapted to measure alcohol involvement. Use of cocaine and opiates in the past 30 days was assessed using an abbreviated version of the Addiction Severity Index (ASI). Radio Immune Assay (RIA) analysis of hair samples was used to verify self-reported drug use.

What were the outcomes? Adults assigned to MI averaged lower reported total consumption (SECs, p = .04) and fewer reported drinking days per week (p = .02) at 6-month follow-up relative to adults assigned to usual care. In addition, those assigned to MI continued to average fewer drinking days per week at 12-month follow-up relative to adults assigned to usual care (p = .04). Students entering college with a history of alcohol use who received MI feedback were more likely than controls to report, on average, greater decreases in drinking quantity, peak amounts of alcohol consumed, and drinking frequency at 6-month follow-up. Except for drinking frequency, all of these outcome differences were statistically significant (p < .02). MI is also significantly associated with a decrease in the negative consequences or problems associated with alcohol use in studies of college students for an extended period after the intervention. At a 2-year follow-up, high risk students who were MI recipients averaged fewer alcohol-related problems in the past 6 months (3.3, +/-3.5) compared with high-risk students in the no-treatment control condition (4.7, +/- 4.4; p < .021). With respect to drug use, MI recipients in an experimental study were more likely to be abstinent from cocaine and heroin 6 months after the intervention than those assigned to usual care. Percentages of abstinent MI and usual care participants at 6-month follow-up, respectively, were 22.3% and 16.9% for cocaine, 40.2% and 30.6% for opiates, and 17.4% and 12.8% for both cocaine and opiates. On average, recipients of MI treatment have a higher rate of retention in therapy than those receiving standard care.

What did you learn? MI is an effective practice for treating individuals with drug and alcohol abuse issues. Its effects are sustained from periods of months to years after treatment, and retention in treatment is higher than that of standard care. Training for clinical supervisors through the MIA-STEP manual provides for a unique level of quality oversight and includes important information on organizational factors that affect fidelity and sustainability of this practice.

Where can I get more information? http://www.motivationalinterview.org

Why is this a best practice? This practice has been shown to be effective in a variety of randomized controlled trials. It has a wide dissemination and acceptance in a variety of communities, and is highly cost effective.
Promising Practice- Washington State: Relapse Prevention Therapy (RP)

Background: Relapse Prevention therapy is a cognitive behavioral approach to helping the individual avoid backsliding or worsening of behaviors related to substance use. It was designed with specific attention to the nature and causes of setbacks, and suggests coping strategies to maintain positive change.

How does it work?
Relapse Prevention Therapy (RPT) is a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. RPT can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training is the cornerstone of RPT, teaching clients strategies to:

- Understand relapse as a process
- Identify and cope effectively with high-risk situations such as negative emotional states, interpersonal conflict, and social pressure
- Cope with urges and craving
- Implement damage control procedures during a lapse to minimize negative consequences
- Stay engaged in treatment even after a relapse
- Learn how to create a more balanced lifestyle

Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity.

What was the Development Timeline? RPT was first implemented in 1977. Although the exact number of sites implementing RPT is unknown, a 1999 meta-analysis of the research literature reported 26 studies that evaluated the effectiveness of this therapeutic approach for substance abuse with more than 9,000 participants.

How much does it Cost? Practitioner training and consultation workshops generally run about $4,000 per day and range in duration from 2 to 5 days, depending on the resources already in place and the treatment goals and needs of a particular site. Workshop costs vary with site-specific factors such as the setting, length of existing treatment program, number of clients and practitioners, and credentials of the practitioners on site.

Treatment manuals that were developed as part of federally funded, multisite clinical trials of RPT for specific substance abuse applications (e.g., stimulant use disorders, cocaine addiction, alcohol abuse/dependence) can be downloaded for free from the SAMHSA Web site. Clinical guidelines for Relapse Prevention Therapy can also be downloaded for free from the Behavioral Health Recovery Management Web site.
How was it Measured? Drinking behavior was measured using the Timeline Followback (TLFB) method. Smoking abstinence was measured using monthly, mail-in postcards that asked clients to report their "current number of cigarettes per day" and "total number of cigarettes for the month." Additionally, at a face-to-face, 12-month postintervention assessment, clients were asked about their tobacco use in the previous 6 months and provided a saliva sample that was tested for thiocyanate concentrations at or above 80 ug/ml, a biochemical marker of smoking exposure in the past 10 to 14 days. Cocaine use was assessed by (1) a composite cocaine subscale derived from a modified version of the Addiction Severity Index (ASI) and (2) self-reported days of cocaine use in the prior month, verified at each follow-up assessment by urinalysis. Marital adjustment was measured using the Marital Adjustment Test (MAT), a 15-item self-report instrument administered to both the husband and wife.

What were the Outcomes? Participants in a study that combined therapy with relapse prevention treatment reported significantly more days abstinent than therapy-only participants at the 6-month (p = .027), 12-month (p = .028), and 18-month (p = .05) follow-ups. These differences were associated with medium effect sizes (eta-squared = 0.0625 to 0.0841). In a study examining smoking abstinence, participants in an RP skills-training condition reported greater initial abstinence rates, and sustained smoking abstinence over the 12 months of follow-up, with a lower rate of relapse relative to participants in both a discussion group and a no-treatment condition (p = .04). Among clients assigned to the RP conditions in a cocaine use study, those with high levels of cocaine use at baseline (> 4.50 grams weekly) reported longer periods of sustained cocaine abstinence during treatment than those with low levels of cocaine use at baseline (1.00-2.50 grams weekly; p = .05) and remained in treatment longer (attended 8.6 vs. 6.0 sessions, respectively; p < .03). Clients assigned to the RP conditions reported less frequent cocaine use in the prior month (p = .03) and fewer problems associated with cocaine use (ASI cocaine composite subscale score, p = .01) at the 6- and 12-month follow-ups compared with clients in the clinical management conditions. A study of marital adjustment in couples with an alcoholic husband showed that couples (both husband and wife) assigned to therapy plus RP reported higher marital adjustment at the end of treatment and throughout the 24-month follow-up assessment than before study entry (p < .001).

What did you Learn? Relapse prevention is more effective than treatment as usual for a variety of substance use issues. A large number of materials are available to support implementation, many of which are easily accessible through the Web. A comprehensive training workshop program offers a wide array of information on substance abuse treatment for diverse populations coupled with clear guidance for the use of this intervention. Outcome measures and general evaluation guidance are available to support quality assurance. However, the burden of identifying and selecting the essential materials from among the many available is placed on the implementer. Very little guidance is provided on the organizational, staffing, or supervision requirements for implementation. Beyond the training workshops, no ongoing coaching, booster training, or supervision training is available. Little guidance is provided on how to identify, use,
and interpret the available outcome measures. No standard measures for assessing fidelity are provided.

**Where can I get more information?**
George A. Parks, Ph.D.
Community Training and Program Dissemination Coordinator
Addictive Behaviors Research Center
Department of Psychology
University of Washington
Box 351629
Seattle, WA 98195-1629
Phone: (206) 685-7504
Fax: (206) 685-1310
E-mail: gparks@u.washington.edu

**Why would this be a Promising Practice?**
Peer reviewed studies of RP treatment have indicated a clear positive effect on reducing relapses. However, higher cost and lack of ongoing assessment of program fidelity present a problem in disseminating this form of treatment reliably.
Background: TFCBT was originally developed for child victims of sexual abuse and their nonabusive parents. It has since been expanded to treat other traumatic events in a child’s life. Numerous therapy and treatment techniques are currently being added to broaden its scope of treatment.

How does it work?
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model: Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format.

What was the Development Timeline? Since its development in the late 1980s, TF-CBT has been adapted by therapists across the United States and in Australia, Cambodia, Canada, Denmark, Germany, the Netherlands, Norway, Pakistan, Sweden, and Zambia. It has been used with children in foster care and with those who have suffered multiple and diverse traumas, including the September 11 terrorist attacks and Hurricane Katrina. More than 10,000 mental health professionals have completed the free training that was made available on the TF-CBT Web site in 2005.

How much did it Cost? The cost of implementing TF-CBT varies depending on the intensity and scope of the training needed for therapists. Several training options are available. Ten hours of free introductory TF-CBT training can be accessed on the program Web site, http://tfcbt.musc.edu/. Low-cost training is available through professional conferences and associations, and more intensive training is provided via graduate training programs and postdoctoral fellowships at various universities. In addition, on-site introductory and advanced training is available from the program developers and trainers who have completed the train-the-trainer program. This option costs approximately $4,000-$18,000 for 2-3 days of training.

How was it Measured? Child behavior problems were measured using two instruments completed by parents: the Child Behavior Checklist–Parent Version, and the Weekly Behavior Report, which documents the frequency of 21 PTSD-like behaviors. Symptoms of PTSD were also measured using the PTSD section of the Schedule for Affective
Disorders and Schizophrenia for School-Age Children (K-SADS-PL). Child depression was measured using the Child Depression Inventory, and feelings of shame were measured using the Shame Questionnaire. Parental reaction was measured using three instruments: the Parent Emotional Reaction Questionnaire, Parenting Practices Questionnaire (PPQ), and the Parent Support Questionnaire.

**What were the Outcomes?** In one study, children in the group receiving TFCBT had a statistically significant decrease in behavior problems from pre- to posttreatment relative to those in the comparison group (all p values < .05). They also exhibited significantly fewer depression (p<.05) and PTSD symptoms at posttreatment than those in the comparison group (p<.01). Children in the intervention group continued to have fewer PTSD symptoms than those in the comparison group at 6- and 12-month follow-up (all p values < .01). Children in the intervention group also had significantly greater improvement with regard to feelings of shame from pre- to posttreatment than those in the comparison group (all p values < .01). At 6- and 12-month follow-up, children in the intervention group continued to report less shame than those in the comparison group (all p values < .01). Guardians receiving the intervention reported significantly greater use of effective parenting skills at posttreatment than did those assigned to the child-only group or the comparison group (p < .01). In another study, guardians assigned to the intervention group showed greater improvement in support of the child victim and in effective parenting practices from pre- to posttreatment than those in the comparison group (all p values < .01). At 6- and 12-month follow-up, guardians in the intervention group continued to report less abuse-specific distress than those in the comparison group (all p values < .05).

**What did you Learn?** TFCBT is a highly effective treatment for reducing symptoms of PTSD, symptoms of depression, and feelings of shame in a child who has experienced trauma. In addition, it creates improvements in guardian parenting and support behaviors. Researchers paid careful attention to ensuring treatment fidelity and examined the possible differences between children assigned to different treatment conditions and between treatment completers and noncompleters. Implementation materials are thorough, practical, logically organized, and easy to understand. Clinician qualifications are clearly described. Therapeutic scripts suggest multiple options for cultural adaptations.

**Where can I get more information?**
http://tfcbt.musc.edu/

**Why would this be a Best Practice?** TFCBT has been extensively studied in randomized, controlled trials, and shown to have a significant positive impact on child mental health and guardian parenting skills. The costs of implementation are low, implementation is straightforward, and it has been effective in a variety of cultural settings.
Best Practice- Washington State: Triple P- Positive Parenting Program

Background: The Triple P program was designed to help parents become self-sufficient in managing problem behaviors in their children. It was designed to improve family relationships and promote child social development.

How does it work? The Triple P--Positive Parenting Program is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers ages 13 to 16. Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which also can be used for early intervention and treatment, is founded on social learning theory and draws on cognitive, developmental, and public health theories. Triple P has five intervention levels of increasing intensity to meet each family's specific needs.

What was the development timeline? Development of Triple P began in Australia in 1977, with research findings on the program first published in the early 1980s. Since then, the intervention has been examined in a series of controlled outcome studies with results published in more than 20 articles. More than 25,000 service providers around the world have received professional training in Triple P. The program has been implemented in Australia, Belgium, Canada, England, Germany, Hong Kong, Iran, the Netherlands, New Zealand, Singapore, Switzerland, and the United States.

What does it cost? The estimated cost for a service provider to prepare for Triple P implementation ranges from $900 to $1,500, depending on the level and variant of Triple P to be used. This cost figure includes professional Triple P training and the practitioner resources needed to conduct the intervention. Training on Triple P, available from Triple P America, includes two parts delivered on site. Part 1 is a 2-, 3-, or 5-day training that conveys program content through didactic sessions, exercises, and some skills practice. Part 2, a 1-day training conducted 8-10 weeks after Part 1, provides an opportunity for intensive practice with feedback. Participation in both parts is required to receive official accreditation as a Triple P practitioner. Training costs for each Triple P course include the course fee (a flat fee that covers up to 20 participants and the trainer traveling to the organization's site) and the cost for Triple P practitioner materials prorated for the number of participants in the course. Training materials include a Participant Notes course booklet that guides the training sessions, a practitioner kit (manual, sample parent materials), and a DVD to show to parents. Implementation materials, which vary depending on the level and type of Triple P, are the parenting resources used in the interventions and include parent workbooks ($20-$28), positive parenting booklets ($10), and parenting tip sheets ($8-$11 for a set of 10). Ordering information is available on the Triple P America Web site at http://www.triplep-america.com.
How was it measured? Negative and disruptive child behaviors were measured by systematic, direct observation using the Family Observation Schedule and by parental reports using the Eyberg Child Behavior Inventory, the Parent Daily Report, the Strength and Difficulty Scale, and the Child Attention Problems Rating Scale. Negative parenting practices were measured by systematic, direct observation using the Family Observation Schedule and by self-report using the Parenting Scale, the Parenting Sense of Competence Scale, and the Depression-Anxiety-Stress Scale. Positive parenting practices were measured by self-report using the Parenting Scale and the Parenting Sense of Competence Scale.

What were the outcomes? Parents of families who received Triple P reported fewer child behavior problems (p < .001) and lower problem intensity (p < .001) than parents of control group families. They also reported fewer conduct problems (p = .002), peer problems (p = .03), and emotional symptoms (p = .03) and less hyperactivity (p = .03) than parents of control group families (p < .005). In an analysis of the clinical significance of outcomes, 77% of families who received Triple P underwent clinically reliable change in child problem behavior, compared with only 18% of control group families. Parents of families who received Triple P had larger reductions in the overall reported use of dysfunctional parenting (p < .05), including subscale scores for laxness (p < .05), overreactivity (p < .05), and verbosity (p < .05), than parents of control group families. This finding was still statistically significant at 12 and 24 months following the intervention. Compared with control group families, a greater proportion of families who received Triple P reached reliable change in a positive direction on parental reports of parenting satisfaction (p = .005).

What did you learn? Triple P reliably and significantly reduces problem behaviors in children as well as negative parenting practices. These effects have been replicated in a variety of geographic areas and cultures. Extensive training and implementation support is accessible to implementers through the Triple P Practitioner Network. An array of standardized assessment instruments is provided to implementers to measure the progress of families participating in the program.

Where can I get more information? http://www.triplep-america.com

Why would this be a best practice? Triple P has been extensively evaluated and shown consistent positive results in improving parenting skills and reducing problem behaviors in children. Its levels of treatment help participants to accept and utilize this treatment as it applies to their families. Implementation is fairly straightforward, and cost is reasonable.
Best Practice- Washington State: Parent Child Interaction Therapy

**Background:** PCIT developed from the ideas of these early play therapists, which originated in psychodynamic and client-centered thinking, made sense in play therapy. While working at Oregon Health Sciences University, Sheila Eyer discovered the work of Diana Baumrind on how different parenting styles (authoritarian, permissive, and authoritative) affect children. This set of parenting behaviors bridged the gap between the behavioral and the more traditional approaches to child therapy -- and added further to the foundation of PCIT. The work of a fourth psychologist, Constance Hanf at OHSU Crippled Children’s Division, contributed the structure to PCIT. Hanf’s program provided a structure that would work for teaching parents play therapy skills.

**How does it work?** PCIT involves highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver-child patterns.

**What was the development timeline?** PCIT was originally developed by Sheila Eyberg in the late 1970s incorporating components of behavior therapy, play therapy, family systems, and social learning theory. Cheryl McNeil and Toni Hembree-Kigin published a step-by-step guide for clinicians in 1995. Treatment manuals and video tapes are continually being developed to train therapists.

**What does it cost?** Approximately $600 per family.

**How was it measured?** Eyberg Child Behavior Inventory, Sutter-Eyberg Student Behavior Inventory, Beck Depression Inventory, Parent Hassles Scale, Parenting Locus of Control, report of child abuse

**What were the outcomes?** PCIT outcome research has demonstrated statistically and clinically significant improvements in the conduct-disordered behavior of preschool age children. After treatment, improvements were seen in measures of child behavior, and parent locus of control. A number of studies have documented the superiority of PCIT to waitlist controls and to parent group didactic training. In addition to significant changes on parent ratings and observational measures of children’s behavior problems, outcome studies have demonstrated important changes in the interactional style of the fathers and mothers in play situations with the child. In a study of abusive parents, those in the PCIT treatment condition were less likely to be re-reported for physical abuse (19%) than parents in the CG control condition (49%) over a period of 850 days following the conclusion of the intervention. Parents show increases in reflective listening, physical proximity, and prosocial verbalization, and decreases in sarcasm and criticism of the child after completion of PCIT. Outcome studies have also demonstrated significant changes on parents’ self-report measures of psychopathology, personal distress, and parenting locus of control.
**What did you learn?** PCIT is an effective way to produce lasting improvements in child behavior and parent-child relationships.

**Where can I get more information?**
http://pcit.phhp.ufl.edu/

**Why would this be a best practice?** This practice is mature, and has well documented outcome studies showing positive gains in social skills for both parents and children. It has modest implementation costs and training is easily accessed.
Best Practice- Washington State: Multisystemic Therapy

**Background:** Multisystemic Therapy (MST) was developed in the late 1970s to address several limitations of existing mental health services for serious juvenile offenders. These limitations include minimal effectiveness, low accountability of service providers for outcomes, and high cost.

**How does it work?** Multisystemic Therapy (MST) for juvenile offenders addresses the multidimensional nature of behavior problems in troubled youth. Treatment focuses on those factors in each youth's social network that are contributing to his or her antisocial behavior. The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and achieve these outcomes at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization. The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources. MST is delivered in the natural environment (in the home, school, or community). The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring weekly. MST addresses risk factors in an individualized, comprehensive, and integrated fashion, allowing families to enhance protective factors. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral, and pragmatic family therapies.

**What was the development timeline?** Multisystemic Therapy (MST) was developed in the late 1970s. It addresses several limitations of existing mental health services for serious juvenile offenders which include minimal effectiveness, low accountability of service providers for outcomes, and high cost.

**What does it cost?** Overall costs for MST programs are determined by staff salaries and therefore vary widely across regions and cities depending on prevailing salaries and cost of living. In the United States, program costs (inclusive of staff, administrative, training, and quality assurance costs) typically range from $6,000 to $9,500 or more per youth served. Additional information on program costs is available from the intervention developer.

**How was it measured?** Arrest and incarceration data was collected from archival databases and sentencing information. The Self-Report Delinquency (SRD) scale was used as a self report of criminal behavior. Urinalysis tested for drug use. Perceived family functioning was measured using a self-report measure of parent and youth perceptions of family functioning using the 20-item Family Adaptability and Cohesion Evaluation Scales (FACES-III). Peer relations were assessed through adult and youth reports concerning the adolescent's friendships using the 13-item Missouri Peer Relations Inventory (MPRI).

**What were the outcomes?** Compared with youth receiving treatment as usual, youth receiving MST were arrested about half as often in the posttreatment period. Recidivism
rates were 42% for the MST-treated youth compared with 62% for youth receiving usual services (p < .05). In a second study, MST was more effective than individual therapy in preventing rearrests for violent offenses during the follow-up period (p < .001). At the end of 4 years of follow-up, the rate of criminal recidivism (rearrest) for the MST completers (22%) was less than one third the overall rate for IT completers (71%). At 13.7 years after treatment, MST participants (then aged 29 years) showed significantly lower rates of criminal recidivism (50%) than comparable youth (81%) (p < .0001). MST participants had on average 73 fewer days of incarceration than youth receiving usual services (p < .006). More than two thirds (68%) of youth in the usual-services group were incarcerated after treatment, compared with only 20% of the MST group. Almost 14 years after treatment, MST youth were sentenced to fewer than half as many days of incarceration as the comparison youth (p < .01). Posttreatment reports of alcohol and marijuana use and other drug use were less frequent among MST participants compared with youth in the comparison condition, p < .05. Posttreatment assessments showed that family cohesion increased among families receiving MST and decreased among families in the usual-services condition (p < .05). Reports of aggression with peers decreased significantly for MST participants, but remained the same for youth in the usual-services condition (p < .05).

What did you learn? MST has been shown to be effective at reducing criminal recidivism in juvenile offenders. Its broad focus on the interaction of peer, family, school, and other social systems allows a comprehensive treatment plan. In addition, it is extremely well suited for dissemination. The operational manual is thorough, detailed, and logically sequenced. Comprehensive costing and financial sections are provided to support organizational implementation. Initial and booster trainings are available, as well as ongoing organization and quality assurance support.

Where can I get more information? www.mstservices.com

Why is this a best practice? MST has shown positive effects on the social functioning of juvenile offenders in several experimental studies. It is mature, and highly cost effective when compared to out of home placements.
Best Practice- Washington State: Aggression Replacement Therapy

**How does it work?** Aggression Replacement Training® (ART®) is a multimodal psychoeducational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. Skill-streaming uses modeling, role-playing, performance feedback, and transfer training to teach prosocial skills. In anger-control training, participating youths must bring to each session one or more descriptions of recent anger-arousing experiences (hassles), and over the duration of the program they are trained in how to respond to their hassles. Training in moral reasoning is designed to enhance youths’ sense of fairness and justice regarding the needs and rights of others and to train youths to imagine the perspectives of others when they confront various moral problem situations. The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders thrice weekly. The 10-week sequence is the “core” curriculum, though the ART® curriculum has been offered in a variety of lengths. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning. The program relies on repetitive learning techniques to teach participants to control impulsiveness and anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking.

**What was the development timeline?** Aggression Replacement Training is a program developed over a 15-year period by professor Arnold P. Goldstein at the Center for Aggression Research, Syracuse University, USA, Dr. Barry Glick and Dr. John Gibbs.

**What does it cost?** $2000 for therapist training, $745 per youth

**How was it measured?** The ART® program has been evaluated in numerous studies. Most studies used databases of criminal convictions to examine recidivism. Others used established psychometric evaluations.

**What were the outcomes?** For the 21 courts rated as either competent or highly competent in a 1999 WA state study, the 18-month felony recidivism rate is 19 percent. This is a 24 percent reduction in felony recidivism compared with the control group, which is statistically significant. Other studies showed that it enhanced prosocial skill competency and overt prosocial behavior, reduced the level of rated impulsiveness, and decreased (where possible) the frequency and intensity of acting-out behaviors and enhanced the participants’ levels of moral reasoning. However, many of the studies did not provide a demonstrated effect on violent behavior or on other conduct problems 1 year or longer beyond baseline.

**What did you learn?** When ART is delivered competently, the program reduces felony recidivism and is cost effective. For courts rated as competent in delivering ART during 2000, there was a 24 percent reduction in 18-month felony recidivism compared with the control group, which is statistically significant. There is clear evidence that outcomes for
ART have improved between its first and second year of operation in Washington, presumably because the courts and program instructors are getting better at delivering ART.

Where can I get more information?  
http://artgang0.tripod.com/

Why is this a best practice? Independent reviews have shown ART to be an effective means of reducing recidivism rates in juvenile offenders when delivered competently. Its cost effectiveness has made it one of the most widely used programs in the Washington State court system.
Promising Practices- Washington State: Family Integrated Transitions

Background: In 2000, the Washington State Legislature established the need for a treatment-oriented program to transition juvenile offenders with the co-occurring disorders of mental illness and chemical dependency back into their community. Because there was no existing model for this population, the specific approach adopted by JRA, called the Family Integrated Transitions (FIT) program, was designed and implemented by Eric Trupin, Ph.D. and David Stewart, Ph.D., from the University of Washington.

How does it work? FIT combines Multisystemic Therapy, Dialectical Behavior Therapy, Motivational Enhancement Therapy, and Relapse Prevention techniques to meet the unique needs of these youth and their families. Family strength-based services begin 2 months prior to release to ensure engagement and strengthen community supports. FIT continues for 4 months after release. The first and most important task of FIT is to engage the family in treatment. Then the program strives to promote behavioral change in the youth’s home environment, emphasizing the systemic strengths of family, peers, school, and neighborhoods to facilitate change. Therapists are available 24/7 and address family and community involvement. They carry low caseloads of 4 – 6 families at a time. Therapists collaborate and partner with JRA residential and community case managers. Both ongoing supervision and expert consultation occur with the provider supervisors and therapists for at least an hour a week each. The consultation and monthly booster training on core treatment elements are provided by the University of Washington. The MST component of the model includes Therapist Adherence Measures (TAMs), which are completed by a family member in regard to the therapist’s performance. The University of Washington staff makes phone calls to family members to obtain this information. In this way, families are empowered to communicate about a therapist’s performance and a therapist can make real-time adjustments to their interventions to match to the needs of the family.

What was the development timeline? In 2000, the Washington State Legislature established the Family Integrated Transitions (FIT) pilot program in order to transition juvenile offenders with the co-occurring disorders of mental illness and chemical dependency back into their communities and families without conflict and reduced recidivism.

How much does it cost? $8,968 per youth

How was it measured? ISCA risk assessment scores, databases of criminal convictions to measure recidivism

What are the outcomes? The evaluation found that the FIT program has a statistically significant effect on the felony recidivism rate. At 18 months postrelease, the felony recidivism was 34 percent less for FIT youth (27 percent) than for the comparison group (41 percent). However, there was no significant effect on the total recidivism rate (including felony or misdemeanor reconvictions), though the results are in the direction of lowering this rate.
There was also no significant effect on the violent felony recidivism rate (which is usually a relatively rare event in the 18-month follow-up period), though the results are in the direction of lowering this rate as well. A cost–benefit analysis of the FIT program indicated that for every $1.00 spent on FIT, $3.15 is saved in criminal justice expenses and avoided criminal victimization.

**Where can I learn more?**

**Why would this be a promising practice?** This program was started in 2000 and has since had one study confirming its positive effects. These outcomes need to be replicated. However, its cost-benefit ratio and high levels of engagement with families and therapists make it a highly beneficial program.
Best Practices- Washington State: Functional Family Therapy

**Background:** FFT grew out of a need to serve a population of at-risk adolescents and families that were under served, had few resources, were difficult to treat, and were often perceived by helping professions to be treatment resistant. In many cases these families entered the "system" angry, resistant, and unmotivated to change. Essentially the "helping professions" did not know how to treat this population. FFT developed out of the awareness that to be successful in treatment of this population we needed to be culturally competent, and understand why this group was so treatment resistant. Thus, FFT attempted to develop ways to engage these families in order to help them achieve obtainable change and become more adaptable and productive.

**How does it work?** Functional Family Therapy (FFT) is a family-based prevention and intervention program for dysfunctional youths ages 11 to 18 that has been applied successfully in a variety of multi-ethnic, multicultural contexts to treat a range of high-risk youths and their families. It integrates several elements (established clinical theory, empirically supported principles, and extensive clinical experience) into a clear and comprehensive clinical model. The FFT model allows for successful intervention in complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive. The model includes specific phases: engagement/motivation, behavior change, and generalization. Engagement and motivation are achieved through decreasing the intense negativity often characteristic of high-risk families. The behavior change phase aims to reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions (skill training in family communication, parenting, problem-solving, and conflict management). The goal of the generalization phase is to increase the family’s capacity to adequately use multisystemic community resources and to engage in relapse prevention. FFT ranges from an average of 8 to 12 one-hour sessions for mild cases and incorporates up to 30 sessions of direct service for families in more difficult situations. Sessions are generally spread over a 3-month period and can be conducted in clinical settings as an outpatient therapy and as a home-based model.

**What was the development timeline?** Since its inception in 1969, FFT has accomplished its primary goals by integrating the most promising theoretical perspectives, the empirical data available, and direct clinical experience with troubled youth.

**What does it cost?** The 90-day costs range between $1,600 and $5,000 for an average of 12 home visits per family. Current costs vary and are highly dependent on cost of labor.

**How was it measured?** Several evaluation studies using matched or randomly assigned control/comparison group designs were conducted between 1973 and 1997. Outcomes were measured by the number and severity of offenses during 2½ years following group assignment.

**What were the outcomes?** In multiple evaluations of FFT, the findings show that when compared with standard juvenile probation services, residential treatment, and alternative
therapeutic approaches, FFT is highly successful. The outcome findings of the research conducted during the past 30 years show that when compared with no treatment, other family therapy interventions, and traditional juvenile court services (e.g., probation), FFT can reduce adolescent re-arrests by up to 60 percent. Moreover, both randomized trials and comparison group studies show that FFT significantly reduces recidivism for a wide range of juvenile offense patterns. In addition, studies have found that FFT dramatically reduces the cost of treatment. A Washington State study, for example, shows savings of up to $14,000 per family. FFT also significantly reduces potential new offending for siblings of treated adolescents.

**What did you learn?** FFT is a highly effective and reliable practice for reducing re-arrests in offenders compared to other treatments. More recently, FFT has been widely adopted because it has evolved an increasingly multicultural perspective.

**Where can I find more information?**
[www.fftinc.com](http://www.fftinc.com)

**Why would this be a best practice?** FFT has been shown to be beneficial to youth receiving treatment across multiple peer reviewed studies and treatment sites. It is cost effective and mature, and fairly straightforward to implement.
Best Practices- Washington State: The Incredible Years

**Background:** The Incredible Years series was developed in the 1980s to promote positive, effective, research-proven parenting and teaching practices that strengthen young children’s social competence and problem-solving abilities, and reduce aggression at home and school.

**How does it work?** The Incredible Years series features three comprehensive, multifaceted, and developmentally based curricula for parents, teachers, and children. The series is based on Patterson’s social learning model, which emphasizes the importance of the family as well as teacher socialization processes, especially those affecting young children. It argues that negative reinforcement develops and maintains children’s deviant behaviors and parents’ and teachers’ critical or coercive behaviors. The parents’ or teachers’ behaviors must therefore be changed so the children’s social interactions can be altered. The parent training series includes three programs targeting parents of high-risk children and those displaying behavior problems. The *Basic* program emphasizes parenting skills known to promote children’s social competence and reduce behavior problems, such as knowing how to play with children, helping children learn, using praise and incentives effectively, and using limit-setting and strategies effectively to handle misbehavior. The *Advance* program emphasizes parent interpersonal skills such as effective communication skills, anger management, problem-solving between adults, and ways to give and get support. It is offered to groups of parents who have completed the *Basic* programs. The *Supporting Your Child’s Education* program emphasizes parenting approaches designed to promote parental involvement in setting up predictable homework routines and children’s academic skills such as reading and building collaborative relationships with teachers. The teacher training series consists of six comprehensive group discussion and intervention programs for teachers, school counselors, and psychologists who work with children ages 4 to 10. Each program concentrates on strengthening teacher classroom management strategies, promoting children’s prosocial behavior and school readiness (reading skills), and reducing classroom aggression and noncooperation with peers and teachers. Group leaders also help teachers discuss important principles and practice new skills through role-playing and homework assignments. The child training series, the *Dina Dinosaur Social Skills and Problem-Solving Curriculum*, emphasizes training children in skills such as emotional literacy, empathy (or perspective taking), friendship, anger management, interpersonal problem-solving, school rules, and how to succeed at school. The series materials consist of a leader’s manual, children’s and parents’ handouts, children’s books, detective home activities manuals, games and activities, and nine videotapes.

**What was the development timeline?** Development of The Incredible Years began in the 1980s and has been continually updated and refined.

**What was the cost?** The costs of curriculum materials, including video or DVDs, comprehensive manuals, books and other teaching aids for the Parent Training Program are $1,300 for the BASIC program, $775 for the ADVANCE program, $1250 for the SCHOOL program; $1,250 for the Teacher Training Program; and $1250 for the Child
Training Program. Discounts are available for purchases of more than one set of any program. Training and technical assistance costs are charged based on a daily fee.

**How was it measured?** All three program components have been extensively evaluated in randomized control group studies with children diagnosed with oppositional defiant disorder or conduct problems. The evaluations have included home and school observations by unbiased evaluators, along with teacher and parent reports on standardized measures.

**What were the outcomes?** Six randomized control group evaluations conducted by the developer and several independent replications by other investigators have revealed that the parent training significantly increased positive family communication and problem-solving, parent use of limit-setting using nonviolent discipline, parents’ bonding and involvement with teachers and classrooms, and parents’ positive emotional response (e.g., increasing praise). Reductions were seen in conduct problems in the children’s interactions with parents, and parental depression. Two randomized control group evaluations of the teacher training indicated significantly reduced child and peer aggression in the classroom, increased children’s positive cooperation with teachers, increased use of praise and encouragement and proactive classroom management strategies by teachers, and increased children’s positive interactions with peers, school readiness, and engagement in school activities. Two randomized control group evaluations indicated that the child training series significantly reduced conduct problems at home and school, increased children’s social competence and appropriate play skills, and increased children’s appropriate cognitive problem-solving strategies.

**What did you learn?** The Incredible Years series has been evaluated and found successful with children from various ethnic groups—including Hispanic, Asian-American, and African-American—and diverse socioeconomic backgrounds in parts of the United States, Canada, and the United Kingdom. It has been shown to be a comprehensive strategy for reducing problem behaviors in children, and improving relationships between children, parents, and teachers.

**Where can I get more information?**

**Why would this be a best practice?** The Incredible Years has been shown to be effective by several randomized studies in various geographic areas. There are many resources available for implementation, and it is well accepted by therapists and consumers.
**Best Practices- Washington State: Multidimensional Treatment Foster Care**

**Background:** Multidimensional Treatment Foster Care (MTFC) is a behavioral treatment alternative to residential placement for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. It is based on the Social Learning Theory model that describes the mechanisms by which individuals learn to behave in social contexts and the daily interactions that influence both prosocial and antisocial patterns of behavior.

**How does it work?** There are three components of the intervention that work in unison to treat the youth: MTFC Parents, the Family, and the Treatment Team. 1. **MTFC Parents.** The program places a youth in a family setting with specially trained foster parents for 6 to 9 months. The foster parents are recruited, trained, and supported to become part of the treatment team. They provide close supervision and implement a structured, individualized program for each child. MTFC parents are supported by a case manager who coordinates all aspects of their youngster’s treatment program. In addition, MTFC parents are contacted daily (Monday through Friday) by telephone to provide the Parent Daily Report (PDR) information, which is used to relay information about the child’s behavior over the last 24 hours to the treatment team and to provide quality assurance on program implementation. MTFC parents are paid a monthly salary and a small stipend to cover extra expenses. 2. **The Family.** The birth family receives family therapy and parent training. Families learn to provide consistent discipline, to supervise and provide encouragement, and to use a modified version of the behavior management system used in the MTFC home. Therapy is provided to prepare parents for their child’s return home and to reduce conflict and increase positive relationships in the family. Family sessions and home visits during the child’s placement in MTFC provide opportunities for the parents to practice skills and receive feedback. 3. **The Treatment Team.** The MTFC treatment team is led by a program supervisor who also provides intensive support and consultation to the foster parents. The treatment team also includes a family therapist, an individual therapist, a child skills trainer, and a daily telephone contact person (PDR caller). The team meets weekly to review progress on each case, review the daily behavioral information collected by telephone, and adjust the child’s individualized treatment plan. There are three versions of MTFC, each serving specific age groups. Each version has been subjected to rigorous scientific evaluations. The versions are MTFC–P (for preschool children, ages 3 to 5), MFFC–L (for latency-aged children, 6–11), and MTFC–A (for adolescents, 12–17).

**What was the development timeline?** The MTFC program model is rooted in studies conducted in the 1960s and 1970s by Gerald Patterson and John Reid at the Oregon Social Learning Center (OSLC). Social learning theory and its principles form the basis for the MTFC model. Numerous research studies have been funded by the National Institutes of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute of Child Health and Development (NICHD) at OSLC and elsewhere to identify key predictors of child and adolescent conduct problems, antisocial behavior, and mental health problems. More than 20 years of research in these areas led to the development of the MTFC model.
**How much did it cost?** The cost per youth is $2,691 per month; the average length of stay is seven months. Training, consultation, and clinical supervision is $45,000 or 49,000 depending on age group for the first year.

**How was it measured?** Eight randomized trials and numerous other studies have provided evidence of the feasibility and effectiveness of MTFC. One study tracked the number of days each youth was incarcerated, as well as information on school attendance, academic advancement, and mental health. Measures also included the PDR Checklist, the Behavior Symptom Inventory, and the tracking of rehospitalizations.

**What were the outcomes?** Overall, the evaluation results showed that MTFC was not only feasible but also, compared with alternative residential treatment models, more cost-effective and led to better outcomes for children and families. Specifically, compared with the control group (GC), MTFC youths spent 60 percent fewer days in incarceration during the 12-month follow-up, had significantly fewer subsequent arrests, and had significantly less hard-drug use. A significantly greater proportion of boys in MTFC completed their programs successfully (73 percent versus 36 percent). In addition, MTFC boys reported significantly fewer psychiatric symptoms, had better school adjustment, returned to their family homes after treatment more often, and rated their lives as happier, compared with boys in GC. More MTFC youth were placed in family settings, while control youth tended to be placed in institutional settings. Significant differences favoring MTFC participants were found in adult reports of child problem behaviors. Findings showed effects at the 1-year follow-up were maintained at the 2-year assessment with a slightly larger effect size and that trajectories of reductions across the course of the study were significantly larger for MTFC.

**What did you learn?** MTFC is a cost effective means of keeping youth out of institutional settings and providing them with a stable home setting. This leads to better psychosocial adjustment and social functioning.

**Where can I find more information?**
http://www.mtfc.com/

**Why would this be a best practice?** MTFC has been shown to be effective in eight randomized, controlled studies. It is highly cost effective and has multiple implementations.
Washington State- Best Practice: Cognitive Behavioral Therapy

Background: In the early 1950’s, Albert Ellis developed Rational Emotive Therapy as a goal oriented reaction to the indirect and time consuming practice of psychoanalysis. In the 1960’s, Aaron Beck built upon this framework to create cognitive behavioral therapy, which was first noted for its effectiveness in treating depression.

How does it work? Cognitive behavioral therapy is based on the idea that thoughts cause feelings and behavior. These thoughts can be tested and modified as necessary to create an accurate, rational perception of life events and relationships. CBT is highly structured, providing the client with homework and exercises to help him or her collaborate with the therapist for the best outcome. It is goal directed and time limited, with the average number of sessions being about 16.

What was the development timeline? The precursor to CBT, Rational Emotive Therapy, was developed in the 1950’s. In the 1960’s Aaron Beck used this model to develop a cognitively directed method of treatment for depression. Since then, CBT has been applied to a vast number of mental health issues including PTSD, psychosis, and substance abuse. It is the foundation for almost all current evidence based practices.

How much does it cost? Costs vary greatly with geographic area and therapist compensation.

How was it measured? CBT has been extensively studied using a great variety of established psychometric tools. The most closely related to the practice of CBT are the Beck Depression Inventory and the Beck Anxiety Inventory.

What were the outcomes? CBT has been shown to be effective at reducing symptoms of mood disorders, anxiety, and substance abuse across populations. It is also being used to treat psychosis and some forms of schizophrenia. Outcomes are unique to each illness, but overall create a reduction in negative symptoms and a more positive outlook, as well as a feeling of greater control over one’s circumstances.

What did you learn? Cognitive behavioral therapy is extremely well documented as a solution to a variety of mental illnesses. It is cost effective and can be used in a variety of cultural settings.


Why would this be a best practice? Cognitive behavioral therapy has been shown to be equal or superior to pharmacotherapy for mood disorders. It has also been shown to be effective for anxiety, psychosis, substance abuse, and some forms of schizophrenia. It is generally accepted as the best approach to behavioral modification, and has been implemented with great success around the world.