# COMMUMITY-BASED PROGRAMS ARE EFFECTIVE IN REDUCING RECIDIVISM RATES FOR VIOLENT JUVNEILE OFFENDERS

Approved by Professor Strobl

# COMMUMITY-BASED PROGRAMS ARE EFFECTIVE IN REDUCING RECIDIVISM RATES FOR VIOLENT JUVNEILE OFFENDERS

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## Abstract

The research paper argues that community-based programs are effective in reducing recidivism rates for violent, high risk juvenile offenders. Community-based programs are reviewed, compared, and contrasted with out-of-home placements or residential treatments. A theoretical framework with social bonding theory and social learning theory best explain why juveniles break the law. Research and studies have proven Multisystemic Therapy (MST) and Functional Family Therapy (FFT) are two of the most effective programs compared to other treatments because they address causal factors identified by social bonding and social learning theories. The paper presents the five factors (individual, family, peer group, community, and school) MST and FFT programs use to achieve successful outcomes. There are recommendations given towards Anger Replacement Training (ART), Intensive Aftercare Program (IAP), Mode Deactivation Therapy (MDT), and Multidimensional Treatment Foster Care (MTFC) to improve the effectiveness of juvenile rehabilitation.

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# I. INTRODUCTION

## Overview of Community-Based Programs

High risk juveniles are suggested by probation officers and judges from the juvenile justice system to become court ordered to community-based programs. Community-based programs are alternatives to incarceration. The community-based programs are created to rehabilitate juveniles in their own community and home environments (Resources, 2016). Treatments are used to hold youth accountable for their behaviors, teach new skills and supervise (Resources, 2016; Lipsey, et al., 2000). There are many community treatment centers but some have proven to be more effective than others in reducing recidivism rates.

## Statement of the Problem

The juvenile justice system aims to reduce recidivism for juveniles. Studies are continuously measuring what works to reduce acts of criminal behavior. According Henggeler & Schoenwalk (2011) community-based programs, during which juveniles can remain at home, are more effective than out-of-home placements. Residential treatments and detention centers have increased violent juvenile's criminal activity making the out-of-home placements ineffective (Henggeler & Schoenwalk, 2011; Lipsey, et al., 2000). Community-based programs (also known as non-residential programs) work with juveniles, their families and their probation officers to help guide them away from violence and criminal activity.

Recidivism occurs when a person relapses into criminal behavior after receiving intervention for a previous or past crime. The National Institute of Justice (2014) defines recidivism under three categories: re-arrest, re-conviction or re-incarceration. The most common

definition of recidivism is re-arrest within three years of being released from a sentence (Recidivism, 2014; Harris, et al., 2011).

When mentioning juveniles, youths under the age of 18 will be referenced. Specifically, the age group in this study is young people between 13 and 17 years old who have broken the law by getting arrested or receiving a charge (Youth, 2015). These young people have been assigned probation officers and are required to meet certain expectations of their probation contract. There are assessments given to categorize youth into three levels: low, moderate (medium) and high risk (Risk, 2015).

Risk levels are often given to each juvenile by juvenile justice practitioners in order to determine the level of risk. Risk factors can be the charge a youth receives (misdemeanor or felony), home environment, the peer group they associate with, social skills, and more. Low risk youth refers to youth who are unlikely to reoffend or continue with delinquent behavior. Usually, low risk juveniles do not need the same amount of services that moderate and high risk will need (Risk, 2015). Moderate risk juveniles may or may not likely reoffend, but they still need more supervision than low risk offenders (Risk, 2015). High risk offenders have a greater likelihood of reoffending in the near future (Risk, 2015). This research will be focusing on moderate to high risk juvenile offenders.

According to Austin, Johnson and Weitzer (2005) juveniles who are chronic offenders and are a safety concern to the public need residential treatment or a confinement center. When juveniles finish residential treatment, it is important that they are not completely cut off from support. If or when juveniles are placed back into society from a residential treatment, they can become overwhelmed and go back to their anti-social behaviors and negative peer group. The

juveniles need a transition period from residential to community-based programs to assist them in using the skills in the real world.

The residential treatment keeps youth from practicing what they have learned with their family and friends (Lipsey, et al., 2000). It is crucial for a juvenile to have assistance with their transition to the community to be successful at home, and with school, employment and the community (Baltodano, Platt & Roberts, 2005). Almost all out-of home placements lack the components for juveniles to engage and practice skills in their environment, with peer groups, or with family.

Another beneficial factor of community-based programs is juveniles can learn skills and use them in real life. The juveniles can practice the skills they are taught from their providers at home, at school, or with their peer group. In residential treatments or secure detentions, the juveniles may learn the skills but they are not able to use the skills in the environment to which they will go back. In community based-programs, youth can learn the skills to practice them at home, school, or with their peer group and receive advice from providers on how to approach challenging situations before they occur. Juveniles who are in residential treatments or secure detentions cannot apply the skills they have learned to the "real world" (Nickerson et al., 2007; Lipsey, et al., 2000).

One of the most effective community based treatments is Multisystemic Therapy (MST). MST is an evidence based therapy focusing on family functional therapy and cognitive learning (Multisystemic, 2015). This program works with the juvenile ages 12 to 17 in their home environment whether that is at the house, at their school, or in their neighborhood (Multisystemic, 2015). MST provides consistent supervision and teaches the youth to learn new effective skills to use in the real world. Another effective community-based treatment is

Functional Family Therapy (FFT). The treatment FFT has found to be effective because it has an essential factor to work with families. The program works with the youth's family to help build structure in the home environment (Sexton & Turner, 2010). Furthermore, community-based programs need to have the components of MST and FFT to be effective.

**Purpose and Significance of the Study**

The purpose of this research is to argue community-based programs are effective for violent, high risk juvenile offenders. Juveniles in residential facilities or secure detention centers should be required to go through community-based programs before they are put back into the community unsupervised. Without having community-based programs, out-of-home placement is ineffective and raises the recidivism rates. Effective community-based treatment programs that contain Multisystemic Therapy and Family Functional Therapy components will help decrease recidivism among violent juvenile offenders. The paper will argue that recommendations towards other programs need to add factors from MST and FFT.

When juveniles transition from residential facilities to community-based programs they are given the chance to practice their skills. The juveniles can apply them in real-life settings with supervision and support. There are many juveniles who get out of residential treatment and go back into the same negative peer group and patterns because they are dropped back into society abruptly with no support or guidance.

The juvenile justice system is always looking for new ways to rehabilitate offenders and improve recidivism rates. Out-of-home placements are important to have for juveniles who have shown they cannot handle themselves in the community without being harmful to themselves or others. These juveniles need high security and structure before they can be released into the community. When juveniles are ready to transition back into the real world, then community-

based programs can help juveniles adjust and receive guidance. MST and FFT factors will be recommended to help improve community-based programs.

# II. LITERATURE REVIEW

## Defining Community-Based Programs

A community-based program facilitates social service providers, organizers, developers and evaluators to serve specific needs to individuals in their own environment (Underwood, et al., 2006). Providers work with individuals who are in need of services, whether they are court ordered or recommended by other services. In regards to this topic, juveniles are court ordered to the community-based programs to help rehabilitate and reduce recidivism rates.

Youth who have come into contact with the juvenile justice system receive supervision and services in the community. Community-based programs provide services in small groups and in suitable places located near or at juveniles' home (Underwood, et al., 2006). There are many different types of community programs for juveniles; some work individually with the juvenile, others in group settings, or with family's involvement. Depending on the programs, the juvenile works with providers to help rehabilitate and guide them toward making pro-social choices in the community (Underwood, et al., 2006).

## History of Juvenile Delinquents

Before modern days, there were no separate institutions or different processes for youth and adults. Youth who committed crimes were punished and incarcerated alongside adults (Schmalleger, 2009). Before the 1900's about ten children who committed crimes were put to death in the United States before they turned fourteen years old. Many other children who were in adult prisons died (Penn, 2001). The adult court system at the time did not take into consideration the lack of cognitive skills and growth that children and youth still had to overcome before they fully understood their behaviors.

Over centuries in the United States, there were many obstacles to separate adult and youth in the criminal justice system. The Supreme Court created new laws and made significant changes to develop the juvenile justice system for youths who have broken the law. In the past, juvenile court procedures were projected to be informal compared to criminal courts (Penn, 2001). However, The U.S. Supreme Court choices since the 1960's have forced due process limitations on juvenile courts and have increased the rights of juvenile offenders but have also created juvenile proceedings to become more formal and similar to criminal courts (Penn, 2001).

The Institutional Era of juvenile justice started in the nineteenth century. In 1824, New York City opened the first house of refuge for children who needed to be rescued and sheltered (Schmalleger, 2009). An average number a house of refuge could hold was up to 200 children but the New York House of Refuge housed over 1,000 children (Juvenile, 2016). The idea was developed because many children were involved in crime and poverty, which led them to becoming thieves, homeless, or runaways. The New York House of Refuge became popular and many cities used it as a model for the homes (Schmalleger, 2009). Decades later, overcrowding, deteriorating conditions, and staff abuse became an issue and the Houses of Refuges ended. (Juvenile, 2016)

During the time of the House of Refuge in New York, the American court system built decisions around the doctrine of *parens patriae* and applied it to the American courts (Schmalleger, 2009). *Parens patriae* was created by the Romans and later used by the English government (Schmalleger, 2009). The law allows the state to take on the parental role for a child. If a child becomes a delinquent, abandoned or in need of care because biological parents are incapable or reluctant, the state will take over (Schmalleger, 2009).

According to Schmalleger (2009) a child-saver movement began in the middle of the nineteenth century. Anthony Platt was an author who wrote several books on delinquency and negative behaviors. Platt recognized the criminal behavior with youth and created new ways to help deter the behavior. He provided a new framework with the idea of using Christian principles and emphasizing individual worth. The Chicago Reform School opened in the 1860's and supported Platt's ideas. The movement focused on pre-delinquent youths who showed trends towards serious criminal interest. The reform schools attempted to follow nourishing family environments to provide safety and affection. However, the reform school was not without its critics and later it was shut down.

In 1870, the Illinois Supreme Court ended the school movement with the support from the case of *People ex rel. O'Connell v. Turner.* Daniel O'Connell was a youth who was committed to the Chicago Reform School under the Illinois law marked as "misfortune." The youth who were under the term "misfortune" did not commit any offenses, but were ordered to the reform school because their families could not take care of them or they did not follow the social norms of society. The *O'Connell* created *parens patriae* could not surpass the power of the biological parents unless there was punishment for crime. The case made the division between criminal and noncriminal behaviors committed by juveniles (Schmalleger, 2009).

In 1899, Cook County, Illinois created the first juvenile court and soon after other states followed (Schmalleger, 2009). Many cases helped alter and improve the juvenile system. In 1967, the case *In re Gault* brought attention to the U.S. Supreme Court of certain rights to juveniles (Schmalleger, 2009). The case was supported by the U.S. Supreme Court to have juveniles entitled to the same constitutional due process rights as adults. *In re Gault* began a

national reform in the juvenile justice system. The juvenile justice system was forced to give youth the same rights that adults have in court (Schmalleger, 2009).

Youth were given the rights to have their parents notified before they were questioned on an alleged crime (Penn, 2001). Also, youth could have their side of the story heard before they were given a punishment or penalty by a judge (Penn, 2001). The juvenile courts also introduced more due process defenses such as the right to counsel (Justice, 2016). Formal hearings were required in cases where youth faced a transfer to an adult court or a long-term institutional confinement (Justice, 2016). The juvenile justice system has gone through many obstacles to create the current system we have today.

There have been many changes over the years for youth to have their own separate justice system. The reform schools brought attention to the needs for youth and helped create the juvenile justice system. New approaches and findings were adjusted or added to better improve the development of the court system for youths. In today's juvenile justice system, the main focus is rehabilitation and reducing recidivism rates to prevent juveniles from becoming adult criminals (Schmalleger, 2009). Until the 1990's the belief was that nothing worked to rehabilitate juvenile offenders. Over the last thirty years, intervention programs have been analyzed and studied to determine what makes programs more effective than the other (Greenwood, 2008).

**Community-Based Treatments vs. Residential Programs**

Residential programs are very different from community-based treatment. Residential facilities have been around for many years and were developed in the United States in the 1920's (Perspectives, 2008). The original intent for inpatient services was to provide services for

children who were abused and neglected and to place them in a safe environment (Perspectives, 2008). However, residential treatments for juveniles are now used for external control and to keep the public safe (Residential, 2010).

According to the Office of Juvenile Justice and Delinquency Prevention (2010) currently, residential facilities do not have a consistent definition because there are many different distinctions between all types of out-of-home placements. The placements can have different program goals, security features, environments, facility size, length of time to stay, treatment services, and a particular target population. Nonetheless, out-of-home placements all share the same factor and that is taking the youth away from their family and out of their home environment (Residential, 2010).

Residential programs house youths because they are a risk to themselves and/or the community. Depending on the risk factors of the youth, they can be in out-of-home placements for different reasons such as psychological, behavioral or substance abuse problems. There are several different types of out-of-home placements: group homes, boot camps or state-hired private facilities. Many residential programs identify themselves as residential treatment centers, however there are placements where they are only punitive and not therapeutic. The structure and types of placements vary state to state (Residential, 2010).

Residential facilities have youths placed in homes where they continue to attend school and live in a family-like environment with close supervision and restrictions. Youths can be in home-like treatment for long term placements, which can lead up to a year. The majority of juvenile facilities are small, holding up to 40 residents or less (Residential, 2010). Residential

treatments are used as a strong external control compared to probation and community-based treatments.

According to The Pew Charitable Trusts (2015) residential treatments, programs and facilities have proven to be ineffective to rehabilitate juvenile's offenders. In fact, studies have shown that out-of-home placements do not lower juvenile offending and in some cases it increases the chances of re-offending. According to Loughran et al. (2009) the authors did a meta-analysis combining multiple evaluations suggesting that placement in correctional facilities does not lower juvenile reoffending and can even increase the chance of reoffending. The study was with juvenile offenders in Maricopa County, Arizona and Philadelphia County, Pennsylvania (Loughran et al., 2009). The study found that when matching youth offenders with 66 factors (demographic, family, peer, legal, psychological, mental health, substance abuse, psychosocial maturity, and prior adjustment factors) did not have a decrease recidivism rates compared to offenders who were on probation (Loughran et al., 2009).

Lowenkamp and Latessa (2005) did a study on Ohio's Reasoned and Equitable Community and Local Alternatives to the Incarceration of Minors (RECLAIM) Program. The study found that low, moderate and high risk offenders placed in a community program had lower recidivism rates rather than placing them in institutions. Both of the studies have proven that confinement does not improve recidivism rates.

Greenwood (2008) states in institutional settings, programs are not effective in improving youth's behavior if the youths are not receiving treatment. Studies have shown treatments focusing on behavior management, interpersonal skills training, family counseling and group counseling and individual counseling have shown positive effects in institutional settings. Out-

of-home placements do not work if there is only confinement and no treatment. However, even though confinement does not reduce recidivism rates the residential programs are still beneficial towards keeping the public and community safe from violent offenders.

Since the 1970's community-based programs and interventions have been around to help deter crime (Underwood, et al., 2006). However, in order to make residential and community-based programs more effective, it is essential they both work together. Juveniles who are transitioning out of residential facilities and into the community need support. Community-based programs can help be that support for the juvenile and their family (Abrams, 2006). If a juvenile comes home from an out-of-home placement, the youth will be less likely to have behavioral issues within the community-based program because they understand there are consequences for their actions.

Another way of using residential services with community treatment can be to have short-term placement. Some private juvenile facilities use this approach. An example of using this method is for continuous or severe violations of a probation contract, breaking the rules of program, partaking in substance abuse or becoming violent. The community-based program could use the residential program as a temporary placement (Sims & Preston, 2006). A juvenile can be placed in a residential facility for short-term until they can take responsibility for their behaviors.

Residential treatments and community-based treatments are very different but they can be beneficial when they are used together (Sims & Preston, 2006). By using both of the programs together approaches can keep the balance and hold the juvenile responsible while making for a better environment to provide treatment services. Juveniles have to learn they can make

mistakes, but they have to understand there are consequences for their negative actions. When applying both services together, rehabilitation can be more effective.

# III. THEORETICAL FRAMEWORK

Professionals and researchers have looked for reasons to explain juvenile delinquency. However, there are numerous and different types of theories that can explain juvenile delinquency. The theoretical framework will help give a better understanding on how and why youth become juveniles. The theoretical perspectives of juvenile behavior and delinquency can assist in examining whether high risk juveniles need to start off or transition into community-based treatments. This paper will focus on two social theories: social bonding theory and social learning theory

## Social Bonding Theory

Social bonding theory is also known as social control theory. In 1969, the theorist Travis Hirschi developed social bonding theory that is influential for social control (Tibbetts & Hemmens, 2010). Travis and Hemmens (2010) found Hirschi's model of social bonding theory is similar to the theorist Emile Durkheim's belief of "We are all animals, and naturally capable of committing criminal acts" (pp. 461). Durkheim's quote means anyone in society can commit a crime if they do not have a form of control. Hirschi's theory is separate from Durkehim because he added influential elements such as families, schools or communities. Travis Hirschi created four elements for social bonding theory: attachment, commitment, involvement, and moral belief (Tibbetts & Hemmens, 2010). The more involved a person is with the four elements, the less likely he or she will commit a crime.

The first element is attachment and it is one of the most important elements. Attachment involves a bond between an individual and their significant others. Psychologist Sigmond Freud also believed the earliest attachment an individual creates makes for a stronger factor in

developing a bond (Tibbetts & Hemmens, 2010). When youth have an emotional connection to others, they are concerned about what they will think of them. Youths constantly seek approval and attention from their peer group and their parents. Parents are the earliest attachment a child has in their life. If the relationship between a parent and their child is a positive one, then the youth has a lower chance of getting into risky situations.

Many juvenile delinquents have poor relationships or attachments with their parents and peer groups. The poor relationships lead them to breaking the law or attention- seeking in negative ways. When there is a strong attachment to antisocial peers, there is a higher chance of participating in delinquent behaviors. When there is an attachment to compliant and pro-social peers, then there seems to have an opposite effect (Hass, 2001).

The second element, commitment, is the association a person has in conventional society. This particular element asks the question, "What is at stake when committing a crime?" If a person can lose a lot when committing a crime, then there is a significantly higher chance of them not committing the crime (Tibbetts & Hemmens, 2010; Flowers, 2002; Hass, 2001). Commitments can include education, employment, positive reputation, goals or personal possessions. An individual will calculate the worth of their commitments in society and decide if it is worth the risk of losing them before committing a crime (Hass, 2001).

If a person has nothing to lose, then they will most likely commit a crime. According to Tibbetts and Hemmens (2010) chronic offenders are harder to control in society because of their lack of commitment. Chronic offenders feel as if they have nothing to lose, leading them into partaking in reoccurring illegal activities. Youth who are committed to work hard in school are

less likely to engage in illegal activities (Tibbetts & Hemmens, 2010; Hass, 2001). Youth who have little to no commitments have no optimism or encouragement for the future.

The third element of social bonding theory is involvement. Involvement is contributing to positive activities to help eliminate time committed to illegal actions. Hirschi argued a person taking an active role can reduce delinquency and criminal activities (Tibbetts & Hemmens, 2010). Youth who are involved in activities such as sports or clubs have a lower chance of being bored or having deviant behaviors. Hirschi missed the likelihood that youths may participate in conventional activities and partake in delinquent activities all at the same time (Hass, 2001). Some conventional activities may even provide a chance for delinquent behavior. According to Hass (2001) involvement is considered the least important element of Hirschi's social bond theory.

The last element is moral beliefs. Moral beliefs involve following the rules and laws in society. Individuals who believe a certain course will go against their beliefs will consider the consequences and reduce the likelihood to commit a crime. When comparing a person who does not have morals, they are more likely to exhibit criminal behavior (Tibbetts & Hemmens, 2010; Flowers, 2002). Youth who believe they are above society's laws or believe they do not have to follow rules are at risk for deviant behaviors.

The understanding of the four elements of social bonding theory can help practitioners in the criminal justice system to better understand why youth become juveniles. Social bonding theory helps explain the different bonds youth have in their lives. However, this theory cannot explain all of the reasons as to why juveniles commit crimes. Another theory that can be applied to strengthen social bonding theory is social disorganization theory. This theory explains more in

depth the bond between youth and the community where he or she lives (Noyori-Corbett & Moon, 2013; Flowers, 2002). Disorganization theory involves a weak bond between youth and community because of a disconnection with members in the community, which leads to more crimes (Flowers, 2002). Therefore, if a youth lives in a high residential mobility and high population community, the higher the chance of delinquency occurring by that youth (Noyori-Corbett & Moon, 2013).

Overall, social bonding theory helps explain why youth participate in delinquent behavior with the four bonds: attachment, commitment, involvement, moral beliefs. Community-based treatments can help create the bonds that are missing in the youth's lives. The bonds are important to help practitioners build relationships with the youth and to help the youth develop positive bonds in the community (Tibbetts & Hemmens, 2010).

**Social Learning Theory**

According to McLeod (2011) in 1971, Albert Bandura created social learning theory. Bandura argues that youth learn through observation and imitation. Individuals who are watched are termed models. Youth are surrounded by different types of role models, such as parents, relatives, celebrities, friends or peer groups (McLeod, 2011). Youth are more likely to imitate models who they want to be like or who they feel are similar to them (Akers, 1990; McLeod, 2011).

People learn criminal behaviors and noncriminal behaviors through the same way. Social learning theory states how people learn criminal and noncriminal behaviors through the method of reinforcement learning (Brauer, 2009). Individuals look for reinforcement or punishment from the behavior they copy. If someone is to receive a positive reinforcement they will continue the

behavior and if it becomes a punishment they consider the consequences (McLeod, 2011; Brauer, 2009; Akers, 1990). Not only do individuals test the reinforcements from themselves, but they also watch others and see if their actions are worth copying (McLeod, 2011). Social learning theory argues human behavior will reflect reinforcement history because individuals seek to capitalize on rewards and reduce punishments (Brauer, 2009; Akers, 1990).

Bandura believed people actively process information about the relationship between their behavior and consequences (McLeod, 2011). The thought process is called meditational processes. There are many different types of consequences or punishments. A punishment can start as small as a parent taking away a cell phone from their teenager to receiving a legal punishment. Many individuals outweigh the consequences before it gets to legal punishment, but then there are those who outweigh the legal consequence and still risk the behavior (Akers, 1990). This involves observing the behavior (stimulus) and copying it or not (response). There are four meditational processes suggested by Bandura: attention, retention, reproduction, and motivation (McLeod, 2011; Akers, 1990).

The first process is attention where youths are exposed to a behavior. When a behavior is going to be imitated, it has to look interesting for youth to copy it. If a peer group looks interested in doing something then the individual youth will want to partake in it. Second, retention means that the behavior is remembered. In order to imitate a behavior, the observer has to recall the memory to perform it. Third, reproduction refers to being able to perform the behavior that was observed. The last process is motivation: does the youth have the will to go through with the behavior? The punishments and rewards are evaluated by the young observer who makes the decision (McLeod, 2011; Brauer, 2009). Some youth use this cost-benefit process

more than others, but the most popular way a person can learn is through remembering and observation.

Before youth become delinquent, they observe the illegal behaviors from others and attempt it themselves. This can involve watching their parents or peers engaging in illegal activities. Parents are children's first role models in the world; they mimic the behaviors and learn from them (Shader, 2004). Take for example if a parent had a serious anger problem and take their aggression out on other people on a regular basis. If a child or youth observed this continuously, they would learn that aggression is "okay" or "normal." This can then lead the youth into getting into fights at school or with friends and ending up with a charge of assault.

According to Brauer (2009) deviant peer involvement has been recognized as the strongest link to an individual's participation with criminal or deviant activities. When youth get into trouble with the law, they usually get into trouble with a friend. Friends and peer groups heavily influence negative behavior. If youth are not learning illegal activities from their family, then they are learning from their peer group. Teenagers have a strong urge to fit in with people their own age and sometimes that means at any cost, even if it means breaking the law. Youth may observe and learn from their peer culture that it is okay to partake in illegal activities such as stealing a car, selling drugs, or getting into physical fights (Shader, 2004).

One weakness of social learning research is a close relation and similarity to differential association theory model. When having both of the models intertwine so closely, it makes it difficult to measure the effectiveness solely on social learning theory. Akers argues differential association theory should be strongly connected with criminal behavior because both of the theories provide alternatives for the learning methods explained by social learning theory. Even

though many have the same agreement that there is a relationship between deviate peer association and individual criminal behavior, researchers argue the motive for the relationship (Brauer, 2009).

Researchers argue the link between the two is confusing because the relationship is flawed when measuring the following, "people seek the company of others like themselves" (Brauer, 2009). Other scholars have recommended the relationship between deviant peer association and criminal behavior could be caused by other theoretical methods such as people looking for deviant subcultures to get rid of stress or to manage negative emotions (Brauer, 2009). Nonetheless, it is important to realize that one theory alone cannot always explain criminal behavior and when mixing other theories together it can give more support.

Overall, the theoretical framework of social bonding theory and social learning theory explained how youth become criminals. Youth become juvenile delinquents by having a lack of bonds in their life. When youth do not have bonds to connect them to their community or to consider their behaviors before acting then they have a higher risk of breaking the law (Tibbetts & Hemmens, 2010). Also, youth can become juveniles by learning negative behaviors from the people around them. The two theories clarified how and why youth become juvenile delinquents in society.

## IV. TWO TYPES OF EFFECTIVE COMMUNITY-BASED PROGRAMS

The juvenile justice system is always looking for effective interventions. There are no programs that can be one hundred percent effective. Nonetheless, there are programs that have been proven to be more effective than others. In order to make a program effective it involves preventing offenders from getting re-arrested, re-offending, or re-incarcerated. Family Functional Therapy (FFT) and Multisystemic Therapy (MST) have been found by many studies to prove to be the most effective community-based programs. The studies have shown the two programs reduce recidivism and have key factors to make them more effective than other juvenile programs.

### Functional Family Therapy (FFT)

FFT was founded in the 1970's by Dr. James F. Alexander. The program is a family-based intervention with a short-term and high valued program with about twelve to fourteen session between three to five months. FFT works mainly with eleven to eighteen year old youth who have been referred for behavioral or emotional problems by professionals from the juvenile justice system, mental health care facility, and school or child welfare systems (Clinical, 2016). FFT has been around for over 40 years and there are currently more than 270 active programs worldwide in four different international settings with therapists treating over 17,500 youth's and families (Henggeler & Schoenwald, 2011; Sexton & Turner, 2010).

FFT can be in an office setting or in a client's home. A therapist acts as the facilitator who works with the youth and their families. A primary goal of an FFT therapist is to have ongoing communication no matter the amount of negativity because it helps keep an open channel of communication. The FFT therapist encourages parenting and problem solving skills

throughout all of the sessions. Research has found FFT has a 35 percent reduction in recidivism rates with severe violent juvenile offenders (Underwood, et. al., 2006). Also, when comparing FFT's recidivism rates to other programs, FFT has proven to be between 25 to 60 percent more effective compared to other programs (Sexton & Alexander, 2000).

FFT Model

Treatment fidelity is also known as therapist adherence, or the level of therapy put into practice that conforms to the academic and technical features of the model (Sexton & Turner, 2010). The model and treatment fidelity plays a large part in making programs effective in community-based settings. Studies have discovered that therapists need to follow closely to the treatment model because it is an important predictor of experimental results (Sexton & Turner, 2010; Henggeler et al., 1997). In certain studies, family therapy sessions have been connected with treatment fidelity. Therefore, it is essential to be aware if a therapist follows a model too closely or not enough since it can limit a therapist in being successful (Hogue et al., 2008; Sexton & Turner, 2010). There needs to be further research with treatment fidelity and community-based programs.

According to both Greenwood (2008) and Sexton et al. (2010) FFT is even more effective when the model is followed, and followed correctly. The model that is taught to therapists has a detailed layout making it easier for the model to be observed and modeled during trainings. There are other interventions that are complex that make it harder to deliver the treatment to youth and their families (Sexton & Turner, 2010). FFT has five primary components: engagement, motivation, relational assessment, behavior change and generalization

(Clinical, 2016). The FFT therapist gives detailed interventions and goals for the families throughout each of the phases.

The first phase is *engagement*. The purpose of engagement is to increase the family members' perception of the therapist as receptive, trustworthy and reliable. The therapist is to demonstrate active listening, encourage the family to ask for help, and show respect to the family members so there is no feeling of judgment. The therapist focuses on immediate responsiveness to family needs and maintaining a strong focus. Also, the therapist engages with the family and reaches out to as many family members as they can (Clinical, 2016; Sexton & Alexander, 2000).

The second phase is to develop *motivation*. The goal of motivation is to create a constructive motivational setting by decreasing family aggression, conflict and blame, and building positive relationships with all of the family members (Sexton & Alexander, 2000). The therapists have the youth and family focus on relationships and learn how to separate blame from personal responsibility. This includes activities of confronting negative interaction patterns, redirecting to a positive approach, and identifying the event and reasoning behind the negative results of behaviors (Clinical, 2016).

My experience at a community-based treatment in the Midwest used the motivation phase. In the program, youth were asked to identify their external (event) and internal (thoughts) trigger of a situation where they wanted to react negatively. The youth would then find out what they were really reacting on whether it was fear, hurt or loss. Then, youth were assisted in disputing their negative thinking (arguing against) their negative thinking by using deterrents. By using this approach, it helps identify negative thinking patterns, making it helpful to break the cycles. This method is also used in the third phase but with in a different context.

The third phase is *relational assessment*. The purpose of relational assessment is to categorize patterns of relations within the family to understand the role for individual family member's behaviors. The focus is to look at all of the family member's values, attributions, functions, interaction patterns, types of resistance, resources and limitations (Clinical, 2016; Sexton & Alexander, 2000). The therapist observes, questions, and gives conclusions on negative behaviors. Relational assessment develops the planning for the next two phases to help the family work through the negative patterns with the behaviors.

The fourth phase is *behavior change*. The goal of this phase is to decrease or remove behavior problems by improving family functioning and developing individual skills. The therapist focuses on communication training, using technical aids, assigning tasks, and training in conflict resolution (Clinical, 2016). The techniques used are evidence-based cognitive teaching to address family functioning. The behavior change phase focuses on modeling and encouraging pro-social behavior, with directions and information (Clinical, 2016). It is essential at this phase that the therapist is able to resolve conflicts with strategies and techniques. The behavioral change phase has to be done by being sensitive to the family members and addressing the family's individual needs.

The last phase is *generalization*. This phase focuses on future challenges, relapse prevention plans, and incorporating community systems within the treatment process. The therapists helps the youth and family get to know the communities better, keep contacts, and develop more resources (Clinical, 2016; Sexton & Alexander, 2000). The core of generalization is to help the youth and family plan for future challenges and to assist the family in becoming independent. Generalization is the ending phase where the family finishes up the remainder of final sessions.

FFT Studies

FFT is well-known known for its effectiveness with a large range of at-risk youths, including those experiencing violence, drug abuse and other delinquency-related problems (Sexton & Turner, 2010). According to Henggeler and Schoenwald (2011) 6 studies (4 randomized scientific trials and 2 quasi-experiments) have been published to show success with clients ranging from status offenders to serious, anti-social behaviors from juveniles. FFT has many studies proving the effectiveness, however, only a select few will be presented in the literature review.

*Study 1*

Sexton & Turner's (2010) study examined the effectiveness of FFT compared to treatment as usual (TAU) (probation services for twelve months after treatment). The project had 38 therapists and 917 juvenile offenders in 14 different counties, both rural and urban (Sexton & Turner, 2010). All of the youth were on probation at the time of the study. The majority of the youth were at high risk for drug involvement and behavioral problems. More than half of the participant's had felonies and/or other misdemeanors before the treatment. Some of the adolescents had weapon crimes, gang involvement, and a history of running away from home, dropping out of school and being placed in institutional settings away from home (Sexton & Turner, 2010).

Sexton & Turner's (2010) findings showed that FFT was effective in reducing a diverse group of violent adolescents but only when the therapists followed to the treatment model. The therapists who closely followed the fidelity to model had a reduction of 35% with juveniles who have committed a felony, 30% involved in violent crime in general and 21% who have

misdemeanor recidivisms, compared to the controlled study (Sexton & Turner, 2010). FFT had a major impact on the families with high risk factors for family and peer. When FFT is delivered by a model adherent therapist after one year, FFT is found effective in reducing recidivism.

*Study 2*

Celinska et al., (2014) assessed the client's satisfaction after participating in FFT. The study done by Celinska (2014) and colleagues used qualitative interviews and quantitative research methods to show the effectiveness of FFT. The data includes having a caregiver interview, a youth interview, service tracking form and the Strengths and Needs Assessment (SNA). In the study, there were 147 participants, 69 adolescents and 78 guardians (Celinska et al., 2014). The study represented a variety of genders and races, but had an average age of 15 year olds among the group.

The interviews had open-ended questions and a sequence of statements with a response on a five-point Likert scale. The scale focused on the relationship with the therapist and the satisfaction with the program (Celinska et al., 2014). The open-ended questions involved asking what they most liked and least liked about the program. The SNA evaluation tool has six scales: the life domain, child strengths', caregivers' strengths', caregiver needs, child behavioral and emotional needs, and the child risk behavior scale (Celinska et al., 2014). The therapists fill out the SNA before and after the FFT intervention.

The results from the interviews reveal from both the parents and the clients had high satisfaction with the therapist and the intervention. From the interviews, the parents had an especially higher satisfaction compared to the youth (Celinska et al., 2014). The parents reported having a significant amount of trust in the therapists, more interaction in family therapy and

more positive views of changes in the family household after the intervention. With the open-ended questions, both parents and the youth appreciated the value of improvements in communication but the youth struggled to change to the adjustment (Celinska et al., 2014).

According to Celinska et al. (2014), two mothers have made positive comments about their experience with FFT. Both mothers have responded on how the communication in their family improved. The first mother's response:

> "I learned better communication skills. I learned to become a little bit more understanding because, maybe, what is so important to me may not be so important to the other person."

Second mother's response:

> "What I liked most is that it helped my family. It helped us to learn how to talk to each other. It helped me as a parent to have a better relationship with my kids…I learned to be a disciplinarian and friend at the same time; it helped us to talk more and to get closer" (Celinska et al., 2014).

From the interviews, FFT has shown both parents and youth were satisfied with the results they received. The study is an indirect link to determining the effectiveness with recidivism of FFT. Parents and youth shared their perspectives and rated how they felt about their experience. The interviews expressed that the youth and parents were satisfied with the treatments that was provided to them. Majority of family's found their experience rewarding, helpful, and educational to improve on their family relationships.

**Multisystemic Therapy (MST)**

Multisystemic Therapy is a concentrated family and intensive community-based treatment focusing on environmental factors to help impact violent juvenile offenders (MST, 2015). MST uses a combination of evidence-based treatments such as cognitive behavior therapy, behavioral parent training, and FFT to address the main factors with juvenile behavior (MST, 2015). Dr. Scott Henggeler discovered and developed the foundation of MST in the 1970's. Between 1992 and 1996, MST began to grow and communities wanted answers on how to use the program (MST, 2015). The formation of MST Services began in 1996 and a license was provided for ongoing clinical training and support services (MST, 2015).

MST Services is the corporate headquarters of MST and they grant agreements to MST programs and provider's to help develop and provide training services worldwide. MST has been introduced in 34 states, 15 countries, over 500 teams, and treating more than twenty three thousand youth a year since 1998 (MST, 2015). Furthermore, there has been more than ten million dollars spent towards MST's research to prove it is effective (Austin, Johnson, & Weizer, 2005).

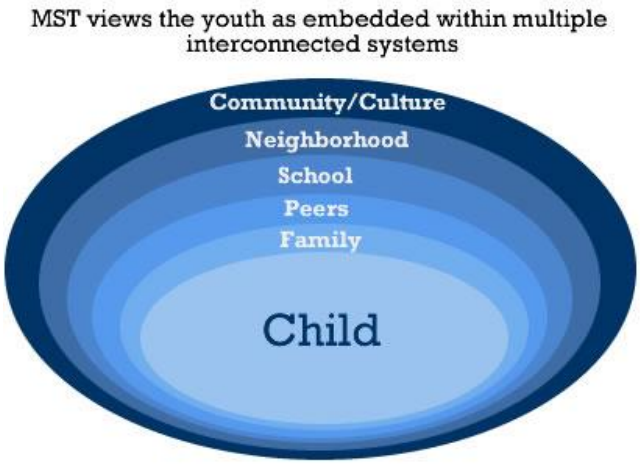
MST master-level therapists work with juveniles between the ages of 12 and 17 who are repeatedly having issues breaking the law and continuously behaving poorly. In order to reduce the juvenile's behaviors and crimes, an experienced MST therapist provides 50 hours of face to face and 24/7 crisis involvement over approximately four to six months (MST, 2015). MST seeks to help and support the youth and their family to build better relationships. With step-by-step guidance from a therapist, MST helps the juvenile interact pro-socially with peers and improve poor school performance. According to Greenwood (2008) a core part of MST is teaching parents to manage their children's behavior problems.

Another important aspect of MST is that clients do not have to go meet at an office to see a therapist because the therapist goes to where the youth lives and spends time where the youth socializes. By doing this, the therapist gets a better understanding of the youth and identifies core problems. A primary focus is on working with juveniles at home, at school, in their neighborhood and with friends. The program focuses on each context because they are essential ones in a youth's life, each context requires attention to effectively help juveniles and their families (MST, 2015).

## MST Treatment Model

According to Henggeler and Schoenwald (2011) MST has a treatment model similar to Bronfenbrenner's theory of social ecology. Youth are surrounded with multiple systems (peers, family, school, etc.) on a day to day basis whether it is direct or indirect involvement. The systems have a large impact on influencing the behavior of youth. MST addresses all of the ecology factors within a youth's life: individual (cognitive), family (affective and influential family members), peer (pro-social vs. anti-social relations), school (academic performance) and community (accessing pro-social activities for youth). The program has become very effective because of the impact a therapist has on all of the factors. The figure below graphically represents the MST model that is closely similar to the social ecology model (MST, 2015)

Figure 1: **Model of the embedded social systems of young people**




Source: MST, 2015

The MST model has proven to be effective by improving the lives of youth and family members. In order for the model to be completely successful, each of the contextual factors has to be targeted. The interventions break the juvenile's negative cycle by increasing caregivers' parenting skills and family relations (family). The intervention can improve the association with friends who do not partake in criminal behavior (peers). Youth can also receive help on academics to get better grades (school). Another goal of MST's model is to have youth participating in positive activities and get involved with support networks in their communities (neighborhood) (MST, 2015). MST can continue to have effective long-term results as long as the model is followed.

A large portion of what makes MST successful is fidelity to the model. MST has nine principles or steps that therapists follow when working with youth and their families. The nine principles are finding the fit, increasing responsibility, focusing on the present, targeting sequences, being developmentally appropriate, applying continuous effort, evaluating and

accountability, and having generalization. Each of the steps provides guidance for the therapist to give the treatment that is needed.

The first principal is *finding the fit.* An assessment is made to identify the problems in the youth's live and to see how the problems occur. The therapist observes the youth's environment and identifies where treatment should begin (Henggeler, 2012; MST, 2015). When finding the "fit" the therapist is able to find the strengths and successes in the youth's life to begin starting the treatment process. Take for example if a violent juvenile has many charges for assault and gets into a lot of fights in the community and at home. The youth shares they choose to fight because they do not know how to control their emotions and they learned from their older siblings to fight when they are angry. Then the therapist can address the issues with the siblings and the parents to find alternative ways and problem solve in order to help control their anger.

The second principal is to focus on the *positives and strengths*. The therapist and team members of the MST program encourage the positives and use strengths in the youth's life to help create and develop pro-social change (MST Treatment, 2007). The therapist also works on the family's strengths to help build motivation and to decrease hostility by teaching problem solving and giving confidence to the caregiver or parents of the youth (MST Treatment, 2007; MST, 2015; Henggeler, 2012).

The third principal is focusing on *increasing responsibility*. Interventions work on different ways to build on responsibility for the youth and family (Henggeler, 2012; MST Treatment, 2007). The family members work on decreasing irresponsible behaviors and setting positive role models for the youth. The youth then learn from example from parents and build on responsibility for themselves.

The fourth principal is *present-focused, action-oriented and well-defined actions*. This principal focuses on current and specific problems that are present in the youth and families life. The therapist looks for ways that action can be taken instantly with visible and apparent problems within the household. All family members are expected to work towards their goals by using present solutions rather than focusing on the past or how they solve their problems in the past. This phase of the intervention is to work towards goals and reach them in positive ways.

The fifth principal is using a *targeting sequence.* The therapist has the intervention address the target series of behaviors within the multiple systems with family, school, friends, home, teachers, or community (MST Treatments, 2007; Henggeler, 2012; MST, 2015). Targeting sequence aims to change family interaction to encourage responsible behavior and bring the multiple systems closer to the youth, especially the family. When the problems are targeted and getting worked through, it makes it easier for relationships to build.

The sixth principal is being *developmentally appropriate*. Interventions are created for the youth's age to fit their developmental needs. Youth need to be able to understand the concepts to fix behaviors with materials they will comprehend (MST Treatment, 2007). A 12 year old is not as developed mentally as a 17 year old and the material that is taught may need to be broken down more to understand. This phase centers on helping the youth build positive relationships with peers and to transition to adulthood (Henggeler, 2012; MST, 2015).

The seventh principal is applying *continuous effort*. In order for the intervention to be successful, daily or weekly effort is needed from youth and family members to show they are committed (Henggeler, 2012; MST, 2015). Youth and families will encounter intensive treatment that will include problem resolution, corrective interventions and continuous evaluation of

outcomes to improve on the interventions and approaches (MST Treatment, 2007). When youth and family are practicing the skills they are taught and continuously making effort, then this gives the family power to make corrections in their own life without assistance.

The eighth principal is *evaluation and accountability*. The intervention created for the families is often evaluated by multiple perspectives from an MST team. The intervention from the therapist is reviewed and evaluated because MST wants to have many different perspectives if a particular intervention is not working for the family. When there are more perspectives and views to look at an intervention for a family, it helps to overcome barriers and reach successful outcomes (MST, 2015). This principal prevents shifting the blame onto the family because the MST team takes responsibility for the interventions when they do not work for the youth or family members.

The last principal is *generalization*. The interventions the therapist designed is to empower the caregiver or parents to address the family's needs when the intervention is over (MST, 2015). The caregiver or parents are given the skills and education to help prevent their youth from making negative behavioral choices. They are the solution to having long-term success with MST (Henggeler, 2012; MST, 2015; MST Treatment, 2007).

The principals are guidelines the therapist has to follow in order for MST to be effective. Not only does MST focus on the ecological factors for a juvenile but the therapists also have to meet certain expectations and guidelines (MST, 2015). The MST therapists have specific training and instructions to make MST as valuable as possible

## MST Studies

MST has been around for a few decades and a majority of research on it has found it effective. Henggeler et al. (1997) has found MST to reduce long-term criminal activity from high risk juvenile offenders. According to Underwood, et al., (2006) research has shown up to a high of 70% decrease in long term rates of re-arrest. Henggeler and Schoenwald (2011) identified 21 published studies, in which 19 were randomized trials and 2 quasi-experimental studies. MST represents a large growing community-based rehabilitation program that has numerous studies to prove it lowers recidivism rates post-treatment. Since MST has many studies on the effectiveness, only a select few will be shared here.

*Study 1*

Both Borduin et al., (1995) Shaeffer & Borduin, (2005) and Sawyer & Borduin (2011) create three different follow-ups of the same study: 4 years, 13.7 years, and 21.9 years. The studies measured how effective MST is with a long-term follow-up of serious and violent juvenile offenders. In Missouri, there were 176 youth who participated in clinical trials with MST or a controlled group having individual therapy (IT). The therapists who provided the MST treatment were recent graduates with experience and they were closely supervised by MST service therapists.

The individual treatment is considered a “normal” treatment that is offered by probation services and does not have the factors of family, school or peer group. Before the interventions, the average youth had 3.9 previous arrests for felonies and 47.8% had at least one arrest for a violent crime (sexual assault, assault and battery with intent to kill, aggravated assault). For both MST and IT, the treatment in both groups was 25 weeks (Borduin et al., 1995; Shaeffer & Borduin, 2005; Sawyer & Borduin, 2011).

The first follow-up was 4 years after the treatment was given. The result after 4 years showed that 26% of the MST group had been arrested at least once compared to 71% of the IT controlled group (Boruin et al., 1995). The difference between the arrest rates is doubled, making MST much more successful. Also, for those who were arrested in the MST group, they were arrested for less serious offenses. Overall, there was an 88% reduction in the average number of arrests, compared to the control group (Borduin et al., 1995).

A second follow-up by Schaeffer & Borduin (2005) was done with the same study but with a13.7 year difference after the MST and IT treatments were complete. The youth after 13.7 years averaged in age about 28.8 years old. The studies showed MST had extensively lower recidivism rates compared to IT. MST clients had 34% less arrests and 57% fewer days of confinement in adult detention facilities compared to IT, which is a significant difference (Schaeffer & Borduin, 2005).

According to Schaeffer and Borduin (2005) about 50% of the MST group was arrested at least once and when measured next to IT, IT had a large percentage of 81%. In addition to the arrests, 14% of MST group had been arrested for a violent offense compared to 30% of the IT group. There was a 54% reduction in the average number of arrests compared to the IT controlled group. Furthermore, about 57% of reduction in the average number of days incarcerated as an adult compared to the IT controlled group (Schaeffer & Borduin, 2005). The Multisystemic therapy arrest and incarceration recidivism rates were still lower than the individual therapy.

Lastly, a third follow-up of the same study was done 21.9 years after the MST and IT treatments were given. The youth after 21.9 years averaged in age about 37.3 years old. Sawyer

and Borduin (2011) results found that MST participants had significantly lower felony recidivism rates than IT: MST had 35% compared to 55%. Also, misdemeanor offending was statistically significant with five times lower for MST participants compared to IT participants (Sawyer & Borduin, 2011). The authors' findings showed that MST has lasting and positive results leading well into adulthood.

*Study 2*

Timmons-Mitchell et al. (2006) examined the effectiveness of MST without the direct oversight of the model developers. MST was compared to treatment as usual (TAU) services. TAU services involved youth getting recommended to drug and alcohol counselors, anger management classes, and individual and family therapies session in both public and private setting. There was an 18-month follow-up for criminal data and a 6-month follow-up for ratings on a Child and Adolescent Functional Assessment Scale (CAFAS). There were 93 youth who were randomly assigned to both of the groups. MST group had 48 youths and TAU had 45 youths (Timmons-Mitchell et al., 2006). Each of the youth had a previous felony conviction and on average approximately seven prior offenses.

At the 18-month follow-up MST group (67%) had statistically significant lower recidivism rates compared to TAU group (87%) (Timmons-Mitchell et al., 2006). The youth in the MST group who were arrested had significantly fewer new offenses in the follow-up period versus TAU. According to the relative risk of re-arrest that was found in the study, it showed the TAU group was statistically significant 3.2 times more likely than youth in the MST group to get re-arrested (Timmons-Mitchell et al., 2006). The CAFAS 6-month follow-up showed MST group

had four areas of functioning improved. The four areas on the scale that showed improvement were school/work, moods and emotions, home and community (Timmons-Mitchell et al., 2006).

**Compare and Contrast FFT and MST**

MST and FFT are two successful in-home treatments helping violent juvenile offenders. Numerous amounts of research have proven the two programs are more effective compared to standardized juvenile service programs (DeVore, 2011). The Blueprints Model Programs by the Center for the Study and Prevention of Violence support MST and FFT in having the highest standards for evidence-based programs (FFT, 2011; DeVore, 2011). Both of the programs are alike but not completely identical (but research shows similar outcomes).

Both treatments work with multiple serious offenders or youth with severe antisocial behavior. This includes youth who have had felonies, youth with many misdemeanors, and youth who have had history of incarceration (FFT, 2011; DeVore, 2011). The programs have frequent and ongoing sessions. The programs are short-term, intense, and meant for treatment goals to be met quickly. The FFT model ranges from 3 to 4 months, whereas MST can be delivered in 3 to 5 months (all depending on the youth and the family).

According to Greenwood (2008) the most successful programs are the ones that emphasize family interactions. Working with families is essential because the skills are given to the adults who are in the best position to supervise and teach their youth when the treatment is done. FFT and MST both require a caregiver such as a guardian or parent to be involved in the youth's treatment (FFT, 2011; DeVore, 2011).

While FFT focuses on behavior problems within the family, MST focuses on the social-ecological and family systems. FFT could be a good treatment for youth whose behavior is

driven by family issues and MST can be a better fit for youth if their behavior is linked to the interaction of family, peers, school, or community (FFT, 2011; Greenwood, 2008). MST will engage other family members, teachers, school administrators and any other adults that supervise the youth (Greenwood, 2008).

The clinical models for both of the programs have similar steps and approaches; take for example the targeting sequence and generalization. Both MST and FFT use related treatment styles to target problem behavior and give the caregivers of the youth the skills and ability to address family needs when the treatment services are over. Also, some of the steps are similar on reducing the behavior conflicts within the youth's life. The models for FFT and MST can be adjusted depending on the clinical needs. This allows the services to be receptive to periods of crisis or to lessen the intensity for families with lower levels of need (FFT, 2011).

MST and FFT handle crisis situations differently. MST teams are available to the family twenty-four hour a day and seven days of the week. If or when a crisis occurs, the family is available to call the direct line to the therapist. Then, the MST therapist or supervisor will help de-escalate the situation over the phone or they will go to the family's home (Greenwood, 2008; FFT, 2011). This of course depends on the severity of the situation. MST gives the availability for the family to call whenever support is needed.

On the other hand, FFT handles crisis situations a different way. When a family is at risk for a crisis or in need of more support, the therapist will increase their availability to meet with the family more. The therapist will also provide the family with crisis prevention plans to decrease the need for after-hour crisis interventions (FFT, 2011). The FFT organization believes the family should not rely fully on formal systems and work through the problems the way the

treatment has taught them. By doing so, it helps empower the family (FFT, 2011). However, FFT does provide crisis services with the family if needed.

# V. RECCOMENDATIONS FOR TREATMENT PROGRAMS

Multisystemic Therapy (MST) and Functional Family Therapy (FFT) are two of the most effective programs for high risk, violent juvenile offenders. The programs focus on five key factors to make a community-based program successful. A review of the factors will give an explanation on why they are essential components for community-based programs. Also, four programs will be reviewed and given recommendations on how to improve their treatment from least effective to most effective. The four programs are Anger Replacement Training, Intensive Aftercare Program, Mode Deactivation Therapy, and Multidimensional Treatment Foster Care. The programs have proven to be more effective compared to other treatments but not as effective as MST and FFT.

## Essential Components of MST and FFT:

MST and FFT have key factors that make them successful in reducing recidivism rates. FFT has found to focus on the factors of family, individual, and peer groups. MST targets the five factors to make a program successful: family, individual, peer group, community and school. Another reason to target the key factors is because they are also "risk factors" for juvenile offenders (Shader, 2004). When community-based programs work with all parts of a youth's life, youth are more likely to change their negative behavior (MST, 2015). The five factors will be broken down and explained why they are needed. Attached below is a table that summarizes the programs discussed and their factors.

Table 1: **Programs for juvenile delinquents and the factors they address**

| | **Individual** | **Family** | **Peer Group** | **School** | **Community** |
|---|---|---|---|---|---|
| ART (Anger Replacement Training) | X | | X | | |
| IAP (Intensive Aftercare Program) | X | X | X | X | X |
| MDP (Mode Deactivation Therapy) | X | X | | | |
| MTFC (Multidimensional Treatment Foster Care) | X | X | X | X | X |
| **MST** | X | X | X | X | X |
| **FFT** | X | X | X | | |

Family Factor

The first and most important aspect for programs and treatment is to target family. Providers and therapists need to have an on-going interaction with the family, whether it is with the parents or legal guardians, siblings or any other members living with the youth's household. For a majority of high risk, violent juvenile offenders, family is a significant risk factor. Family structure is a risk factor when there is poor parenting skills, large family size, maltreatment with children, home conflicts or parents exhibit are anti-social behavior (Shader, 2004).

According to Greenwood (2008) family interactions are the most influential because a variety of skills are provided to the adults, primarily to the parents or guardians. During

treatment, MST and FFT both assist parents or guardians by teaching them increased problem solving skills and guidance to improve on relationships in the home. The adults are in the best position to supervise, guide, and teach their youth to keep them out of future trouble. Working with the family helps improve the home environment with open communication and structure. It is not enough to only work with the parent's one on one but to work with the adults and their youth to develop open communication towards one another. MST provides treatment with any family members who live in the home or family members who come to the home a lot.

Parents and guardians will be with the youth when treatment services finish and youth have completed probation. In order to prevent future delinquency parents are in the best position to prevent youth from relapsing (Fagan, 2013). Parents have to continuously monitor, supervise and discipline youth. The youth have to see their parents or guardians being consistent with parental discipline, otherwise they will not adjust to the pro-social change.

Individual

The second most important factor is the individual. This gives youth one-on-one attention to express their feelings and thoughts. When working with a youth individually, it gives the provider the perspective of the youth in order to understand what needs attention. MST and FFT both target the individual factor in order to help address the needs of only the youth. This can involve solving issues or help guide them to understand others' perceptions.

In the beginning of the treatment process, youth usually struggle to open up with someone new. Trust and relationships are developed through a lengthy process (Underwood et al., 2006). In addition, when youths begin to feel comfortable they discuss personal topics that they may want to work out with a provider before talking with their parents or guardians. As

soon as adolescents begin to open up and communicate honestly, then treatment becomes effective.

There are many different approaches that can be achieved with individual sessions. Studies have shown cognitive-behavior treatment or therapy approaches have been most beneficial with juveniles (Greenwood, 2008). Cognitive-behavior therapy is a short-term, goal-oriented treatment to work on problem-solving. The therapy works on changing the pattern of thinking that leads to the behavior. Youth can work on skill building and practice role-playing to better their skills. Information can be broken down to the youth individually if they do not understand certain material that is taught.

Also, adolescents can receive assistance with academic work and goals can be developed independently from family goals (Greenwood, 2008). Therapists can discuss events in the youth's life and help problem-solve separate issues from what they feel comfortable sharing with family and friends. A majority of community-based programs have a form of individual treatment. In order to have an effective treatment, individual sessions are imperative.

Peer Group

The third most important factor is peer group or friends. Negative peer groups are very influential for youths because they associate together when breaking the law. Studies have found a significant relationship among participation with delinquent peer group and delinquent behavior. Youth in general seek out approval from their peers which easily leads youth into getting involved with peer pressure and deviant behavior (Shader, 2004).

Teenagers want to fit in and when they are put under peer pressure they give into the influence because they do not want to feel left out. When there is negative peer pressure, youth

usually go along with the illegal activity because they do not know how to say no or have low self-esteem. Once youth become involved with negative friends, they continue with the behaviors (McWhirter, et al., 2007). MST and FFT meet with peers and other associates in the youth's life more than once a week. MST works with the youth's friends who do not participate in criminal behaviors and use the friendship as a way to guide the youth into making better choices.

Treatments can target peer groups in several ways. One approach is the treatment provider can discuss with the youth about negative peer groups and break down ways to associate with people who want their best interest. A second approach could be youth participating with other juveniles in a community-based group setting. If the group setting is facilitated correctly, the provider can have pro-social responses influence anti-social responses. This can then lead to positive responses from a majority of the group (Glick & Gibbs, 2010).

However, if the facilitator does not have the group structured correctly, it could risk the treatment and have a negative effect. The facilitator should have control with behavior management and influence the youth by starting with the pro-social responses (Glick & Gibbs, 2010). Anger Replacement Training (discussed later) has group settings that have been beneficial to target negative peer behavior. Overall, peer groups and friends is a topic that needs to be discussed and supervised with juvenile delinquents. Youth's are clouded by their own judgment when it comes to relationships. Youth need to have guidance and support so they do not continue to associate with "friends" who will get them into reoccurring trouble after treatment.

Community/Neighborhood

Community or neighborhood is an important factor, but not as vital as family, individual and peer group. Many theorists and researchers can agree that neighborhoods with high levels of poverty and crime increase the risk of youth engaging in illegal activities (Shader, 2004). The type of community and neighborhood a youth lives or hangs out in can interact with other risk factors. If a youth is around high rates of drug activity and violence, it is harder for that youth to resist the peer pressure in the community (MST, 2015).

MST therapists suggest resources in the community for the family and youth. Funds that could be provided are employment, housing, food stamps or assistance with bills. Having the family and youth reach out to positive resources will help them become more acquainted with the community (MST, 2015). By building support networks in the community, the families youth are aware of the resources they may need in the future when services are no longer provided.

Also, youths can get involved with pro-social activities after school in order to stay busy. They can engage with organizations, clubs, sports, or seek out an after school or weekend job. Youths need to stay as busy as possible in the community with positive activities. It is essential because they could easily fall back into the same criminal patterns if they do not have something to occupy them (MST, 2015).

Another aspect that is not usually associated with treatment for neighborhoods and community is how to act in certain environments or unusual situations. Youths need to recognize the social norms in society and how to behave appropriately in diverse environments because they will come across different roles, people and places throughout their life. Take for example church and a basketball game: people do not usually act the same way in the two different environments. People adjust to the environment and play separate roles (McLeod, 2008).

School

The last important factor is school (also not as essential as family, individual, and peers). Education is significant for children and youth to thrive in society. School is imperative for many reasons and it should be addressed with youth's. Adolescents spend a big part of their day at school and they need to be able to learn how to function appropriately with others (McWhirter, et al., 2007). School is also a place where a lot of youth get into trouble with verbal or physical aggression towards students or teachers. Academics and pro-social behavior needs to be addressed with youth during treatment.

Many times there are signs of school becoming a risk factor, such as youth receiving detention, suspension, failing grades, tardies, truancy, or expulsion. The risks at school can lead to delinquent behavior (Shader, 2004). Some youths struggle more than other students with academic learning and it can discourage them from wanting to show up to school or acting inappropriate in the classrooms. School services should provide youth with support, guidance and encouragement to reach goals.

Youth school and academic performance should be taken into consideration when providing treatment. MST targets school as a factor by communicating with the youth's teachers, staff, and/or principal. Targeting school can be done in several ways. First, the treatment provider can encourage parents to check on absences, tardies, or grades. Second, the provider can receive signed release forms from parents and check on the progress of the youth or communicate with teachers and staff at the school. Third, there can be individual sessions with youth to help brainstorm ways to solve academic problems. Lastly, providers can help set up resources for the youth to receive extra help from teachers or tutors (McWhirter, et al., 2007). All

of the approaches are different ways that school can be addressed within treatment. School does not have to be a big part of the treatment, but even so it needs to be included.

Overall, the five factors of family, individual, peer group, community and school are important pieces to target for treatment. MST and FFT use a majority of these five factors if not all and they have been found to reduce recidivism rates significantly. It is also significant to take into consideration that there are other factors that have an effect during treatment. This can involve needing consistency with the family from the provider (Underwood, et al., 2006). If a provider cannot get a hold of or reach the youth and family it makes it difficult for any treatment to be successful.

Another inconvenient aspect could be ongoing negative behaviors such as lack of cooperation or violence in or out of the home. If the family or youth are unwilling to participate or adjust to working with a provider, it makes it difficult for treatment to get completed or be successful. And this is when the factor external control should come into play. The family and youth should understand if they cannot finish the treatment successfully, then future consequences or placements could occur.

**Anger Replacement Training (ART)**

Anger Replacement Training (ART) is a ten-week course in a community-based facility and has meetings three times a week. The treatment is a cognitive behavioral intervention treatment for children and adolescents to improve on anger management and reduce aggressive behavior. ART occurs in a group setting with a facilitator, co-facilitator, and about six to twelve youths. The treatment is for youths ages between 12 and 17 years old. ART has only two of the targeting factors: peer group and individual. This program has three primary components that

make the program effective: Anger Control, Behavioral Skills, and Moral Reasoning (Greenwood, 2008; Glick & Gibbs, 2010).

The first component is Anger Control. This factor focuses on what triggers the youth's anger individually and how they can control their reactions (Greenwood, 2008). The model is as follows: triggers (external-event and internal-thoughts), cues (body signals), reducers (calm down in the moment), thinking again/reminders (positive self talk), self evaluation (asking themselves if need to go back to reducers), and using a skill to resolve their situation (Glick & Gibbs, 2010). Each part of the model is broke down and taught to the group. The youth learn ways to stop and think before they react and to try a pro-social response rather than acting on their anger.

The second component of ART is Behavior Skills. The skills are pro-social and are used with role playing and performance feedback (Greenwood, 2008). The group is asked to share a personal situation where they could use one of ten skills and role play. There are several skills but a few are "Making a Complaint," "Dealing with Other People's Anger," "Keeping out of Fights and Arguments," and "Dealing with an Accusation." All of the skills have about four to six steps and many times there are three or more thinking steps. The last step is an action step where the youth role plays a pro-social response (Glick & Gibbs, 2010).

The last component of ART is Moral Reasoning. The participants individually share with the group their responses to cognitive conflict problem situations (Greenwood, 2008). The problem situations have names such as "Alonzo's problem" or "Jim's problem." The situations can range from a family member selling drugs to not attending a best friend's birthday party because of an invitation from a basketball team. The participants are asked what they would do

in the situations and to explain why. There are a variety of questions posed about the situations and there are three types of responses: pro-social, anti-social or do not know. Typically, participants begin with anti-social responses and by the end of the ten weeks, they lean more towards pro-social responses (Glick & Gibbs, 2010).

The three components that make up ART have shown to benefit youth. In fact, in the Midwest, a program used ART with low, medium, and high risk offenders. The youth counselors and behavioral providers would reference the Anger Control Chain (ACC) to help youth connect their emotions to their thoughts. ART can be an effective program for youth; however, it only targets the factors of peer group and individual. In which case, only targeting the two factors is not enough to make a significant change for a violent juvenile offender. Family is the most important factor when rehabilitating juveniles and ART does not provide treatment in that area (Greenwood, et al., 2006).

Overall, the treatment lacks the effective factors of community, family, and school. Since the intervention has weaknesses, ART could be more beneficial with out-of-home placements and lower risk juvenile offenders. When comparing ART with MST and FFT, ART's recidivism rates are only at nineteen percent for reoffending (Outcome, 2004). MST and FFT have proven to more than double and even triple ART's recidivism rates. ART is a positive treatment for youth, but without all of the factors, ART is less likely to be effective for high risk, violent juvenile offenders.

**Intensive Aftercare Program (IAP)**

There are some youth who are extremely violent and continue to reoffend even when given services. Extremely violent juveniles gain external control by being placed in an out-of-

home placement because they are a risk to themselves and the community. With that said, youth who leave an incarceration setting need to have a transition so they are not dropped back into the community without support. Intensive Aftercare Program (IAP) is a concentrated community-based program to help transition high risk youths. The IAP model is used for juveniles who are high risk and violent offenders between the ages of 12 and 18-years-old (Gies, 2003).

Just like other services, IAP has a model with five main principals: 1) prepare juveniles for increased responsibility and freedom, 2) smooth the progress of interaction between the youth and the community, 3) supporting the offender and community support systems, 4) developing new resources and supports, and 5) monitoring the youth and community facilities to see if they both can effectively work together (Underwood, et al., 2006). IAP uses the principles to evaluate how youths adjust to the community. If the youth struggles to adapt to the transition, alternative placements will be given.

There are several different locations all over the United States where the IAP model is used such as Colorado, Nevada, and Virginia. Each model for every state slightly varies on the treatment that is given. The Colorado IAP offers vocational skills, individual counseling, parent orientation, experiential learning activities, and anger management and survival skill groups (Gies, 2003). Youths earn supervised trips to the community, and overnight or weekend trips home.

IAP targets all five of the factors (family, community, school, peer group, and individual) with supervision and some treatment. There are a couple recommendations for the program that should be taken into consideration. First, IAP offers a lot of treatment around skills and counseling however, there is a lack of family and individual therapy. Take for example that IAP

has parental orientations that targets the family factor but does not attempt to work through family issues that could be occurring in the family's household. It is not enough to have orientation sessions, because parents or guardians can come to the sessions and not actively participate or engage in problem solving techniques.

A second recommendation is to have more studies to support the IAP model. There were older sources from the 1990's that stated IAP was effective, but the program did not have many statistics on recidivism rates (Gies, 2003). In order for a treatment or program to be effective, there needs to be updated information on how the program evolves and if changes are made. When a program lacks recent, updated evaluation studies or information on progress, it can demonstrate ineffectiveness or lack of deterrence. This can also show that a program is not being used as envisioned. The programs could be removed from the community and no longer offered to youth.

**Mode Deactivation Therapy (MDT)**

Mode Deactivation Therapy (MDT) is a community-based program that is an evidence-based psychotherapeutic method used to treat trauma and personality factors (Swart, et al., 2014). The therapy works on approaches to reduce continuous violent problems like verbal and physical aggression (Thoder & Cautilli, 2011). MDT targets youth between 14 and 18-years-old. The therapy uses cognitive behavior therapy and dialectical behavior therapy (DBT) to address adolescent's attitude and belief system. DBT is a type of cognitive behavior where the therapy helps treat borderline personality disorders and mental health disorders (Swart, et al., 2014).

The treatment has worked with youth who have struggled with outpatient treatments and residential facilities because of continuous aggression (Underwood et al., 2006; Thoder &

Cautilli, 2011). MDT offers individual, family and group therapy sessions weekly (Swart et al., 2014). MDT starts with a case conceptualization, diagnostic interview, complete behavioral history, and a full family history (Thoder & Cautilli, 2011). When MDT finishes the introduction component, the treatment begins with different levels.

MDT has a series of mindfulness trainings that are distinctively planned for violent adolescents. Some of the exercises are located in a client's workbook that are designed to allow the youth to practice coping strategies to help guarantee trust, decrease anxiety and enhance obligation to treatment. The mindfulness skills have youth become aware of their fears, triggers, and beliefs to assist youth in identifying positive strategies to substitute their aggressive behaviors (Underwood et al., 2006). Therapists help the adolescents or families work through and solve behavioral issues.

MDT targets two of the key factors: family and individual. When MDT works with a group setting, the treatment then also targets the peer group. MDT does not target community or school; however, the therapy has shown to confront topics with fundamental youth and their parents or guardians. MDT does not openly talk with the youth's teachers or dynamically engage the youth with activities in the community compared to MST. When a provider expands into other aspects in the youth's life, it improves the trust and relationship with the youth, family and provider.

The recommendation use of this program in light of MST and FFT, would be to get involved and check the progress of the youth with the school and community. By doing this, the therapist can assist youth to solve any issues that could be occurring outside of the individual and family. Also, the therapist should be more active in the youth's home life. A therapist should be

able to engage the family in their home (through home visits) and not just in an office. A program can be more effective if a therapist communicates with more than one family member and understand the perspectives of others within the home.

**Multidimensional Treatment Foster Care (MTFC)**

Multidimensional Treatment Foster Care (MTFC) is a mix between community-based and out-of-home placement because the youths are still in the community but not their families' home. According to Underwood, et al. (2006) MTFC lasts about six to nine months and during the length of stay, the families who supervise the youth help reduce criminal behavior, improve academic performance and attendance, develops positive peer relationships and improve familial relationships (Underwood et al., 2006, Treatment, 2015; Caldwell & Van Rybroek, 2013). When comparing foster care programs, they usually are licensed for six or more youths that do not pose a serious risk to themselves or others; however, MTFC is different.

MTFC parents attend weekly group sessions and have daily contact by telephone with the program case managers (Treatment, 2015; Greenwood, 2008). MTFC has community families recruited and trained to provide for each youth (Greenwood, 2008). The parents of the MTFC youths have many responsibilities, such as the foster parent supervising the youth before and after school. At all times, the foster parents have to be aware or in the presents of their youths location.

The foster parents are trained in behavior management and provide a structured and therapeutic home environment (Greenwood, 2008; Caldwell & Van Rybroek, 2013). An example of a behavior management technique is the foster parents keeping track and controlling the youths' behaviors with a point system. The youth receives points for positive behaviors and have

points taken away for negative behaviors. The more points the youth earns, the more they are able to earn privileges and have less adult supervision (Treatment, 2015; Caldwell & Van Rybroek, 2013).

Individual and family therapy is given to the youth and the youth's biological parents or legal guardian (Greenwood, 2008, Treatment, 2015). MTFC has intensive training to improve the parents or guardians through more constructive methods of parenting. When the biological parents or guardian complete the therapy and the juvenile appears to have improved, then services are terminated. However, there are still intensive parenting trainings that continue for about twelve months after the service (Underwood, et al., 2006).

MTFC has proven to be successful in lowering recidivism rates for incarceration with juveniles by 60% (Underwood et al., 2006). The program has effectively proven to target all of the five factors of family, individual, peer group, community, and school. A recommendation for the program could be to have the youth living in their family environment rather than another family's home. The program did not specify if the youth ultimately live in the same community as the biological parents or the guardian, only that the youth are taken out of their home environment at the time of the program. In which case, this is an important factor because youth will go back to their same community, school, home environment, and family when the treatment service is complete.

Unfortunately, if the youth's biological parents or guardian are in a different location (city or town), then it will be harder for the youth to adjust going back to their old environment where they were able to break rules and the law. It would be more beneficial if the youth stayed in their home and community to practice the skills they were taught in the context of friends and

family (Greenwood, 2008). Also, the program has an external control benefit because if the youth wants to be able to stay in the community, go back home, and avoid going to an out-of-home placement institution, then the youth will be more willing to follow the rules and learn from the providers.

In conclusion, there are many different types of community-based programs that have been proven effective. Nonetheless, MST and FFT are the most effective programs to reduce recidivism rates in the present for violent, high risk juvenile offenders. If other programs worked on focusing on the five factors: family, peer group, community, school and individual treatment then these programs can be more effective too.

The programs Anger Replacement Training, Intensive Aftercare Program, Mode Deactivation Therapy, and Multidimensional Treatment Foster Care can all be interventions used for juveniles. It is important to communicate that if a program does not have the five factors, then the program should be considered at least partially effective. On the other hand, these interventions alone will not have higher recidivism rates or be as effective as MST and FFT. The five factors are risk factors and need to be targeted and under supervision as much as possible.

**Applying the Theories**

The theoretical framework of social bonding theory and social learning theory was applied to better explain juvenile delinquency. Social bonding theory involves having attachment, commitment, involvement, and moral beliefs as bonds that youth should have in order to prevent delinquency (Tibbetts & Hemmens, 2010). MST and FFT work with violent juvenile offenders who lack many or all of the bonds. Social learning theory explains juvenile delinquency through observing, modeling and imitation.

Social Bonding Theory

Youth need pro-social bonds in their life to keep them from breaking the law. The first and most important bond of social bonding theory is attachment. Youth need reassurance and guidance from their family and friends because they are the significant others in their lives. Juveniles who have a poor relationship with their parents or guardian have a higher chance of getting into trouble or breaking the law (Tibbetts & Hemmens, 2010). MST and FFT works with troubled youth and their families to build or improve the bonds in their life. The therapists do this by creating and developing goals and interventions for the youth and their family to work towards. By doing this, the youth are developing a positive attachment with their family.

The second bond is commitment. When adolescents do not have anything to work towards or a commitment, it becomes more likely they will break the law. MST and FFT help the youth get back on track with their relationships at home and commit to improving their life. The services give the youth a commitment to finish the program and work towards their own personal goals (MST, 2015). When youth have something to work towards and feel accomplished, they do not want to lose their improvement.

The third bond is involvement. MST and FFT work with youth and their family to develop new priorities in their lives. Providers assist the youth in finding extracurricular activities because it is important youth stay busy with positive activities rather than going back to the negative routine before with breaking the law (Tibbetts & Hemmens, 2010). MST and FFT guide the youth into getting a job, joining a club, or participating in a sport. The treatment's MST and FFT support and guide youth to get involved in constructive activities before the services end.

The last bond is morals and beliefs. MST and FFT assist the youth in understanding the consequences of their actions. The treatments teach the youth alternative methods they could have used instead of breaking the law. MST and FFT discuss social norms and rules in society and share alternative, pro-social methods. Overall, the four elements of social bonding theory are targeted by MST and FFT in some way during treatment.

Social Learning Theory

Social learning theory is applied when juvenile delinquents observe, model and imitate other people's negative behavior (McLeod, 2011). The way anyone learns how to do something is by watching people who are close to them such as friends and family. Before treatment using MST and FFT, a majority of the negative behaviors and delinquency were already taught to the youth by family and/or friends. Juvenile offenders have a pretty clear understanding on what is "right" and what is "wrong." However, they still choose to justify their behavior because they saw "so-and-so doing it" and believed that it was "okay to do."

MST and FFT work with friends and family of the youth to break off dysfunctional cycles and problem solve conflicts. When using these approaches, MST therapists are teaching appropriate ways to handle difficult situations. Youth and their family observe, model and imitate new skills that are being taught from MST and FFT. After the family has learned pro-social skills, they are able to break the cycle of anti-social skills (Shader, 2004).

MST therapists are with the youth around the clock to work with the youth to solve issues at home, in the community, or at school. MST therapist role plays with the youth new ways to handle difficult situations in their lives. Take for example if a youth is arguing with their sibling about who gets to watch TV first. The provider will teach the youth problem-solving techniques

rather than fighting and arguing. The provider could recommend different options such as making a weekly chart with times or agree on taking turns for every other TV show. The provider can role play the pro-social way to handle the conflict and the youth can practice modeling and imitating the new taught behavior. Overall, the MST provider teaches the youth new ways to handle conflict situations by observing and modeling the new pro-social behavior for the young person to imitate.

## VI. Summary and Conclusion

In summary, high risk and violent juvenile offenders are a large concern for the safety of the community. Juvenile services are always looking for new treatments or programs to improve on reducing recidivism rates. Often times, juvenile courts place high risk, juvenile offenders into out-of-home placements because of the severity of the charges or the danger the juvenile places on themselves and/or others. There are those violent offenders who need strict supervision and rules and institutional settings can provide that.

Unfortunately, out-of-home-placement has proven to be ineffective in reducing recidivism rates and in some cases, make behaviors worse for juveniles when they get out of placement (Re-Examining, 2015, Henggeler & Schoenwalk, 2011; Lipsey, et al., 2000). Youth in out-of-home placement lack treatment and have no support when they transition back into their community and home environment. This then leads youths into going back to the same behaviors they were exposed to before treatment. However, community-based treatments can provide support, guidance, and most importantly intensive treatment to keep the youth and community safe.

Social bonding theory and social learning theory were reviewed and explained as to why youth may commit crimes. When youth's lack pro-social bonds they tend to get into trouble with the law because they feel they do not have anything to lose. Also, when youth are taught criminal-like behaviors from family or friends, it becomes "normal" to the youth when they break the law. Both of the theories were applied to MST and FFT to compare how they relate.

As most researchers and providers in the criminal justice field know, there are no programs that are 100% effective. However, both MST and FFT have proven to statistically and

significantly reduce recidivism rates by up to 60% to 70% (Sexton & Alexander; Underwood, et al., 2006). MST and FFT are similar in some ways but they are not completely identical. However, research has shown significant outcomes with both. Furthermore, both models have proven to address similar needs and components in their treatment.

MST and FFT are effective for many reasons but most importantly because they target the five main factors in a youth's social ecology: family, individual, peer group, community and school. Each of the factors is recommended to be targeted in juvenile delinquents' lives because they have shown to be the most common risk factors to law-breaking (Shader, 2004). The recommendations for Anger Replacement Training, Intensive Aftercare Program, Mode Deactivation Therapy, and Multidimensional Treatment Foster Care are ways to improve recidivism.

Overall, community-based programs are effective for violent, high risk juvenile offenders. If youth have been placed in any type of out-of-home placement, they should transition back into their community with support from community-based programs. The juvenile justice system is always looking for ways to reduce recidivism rates, MST and FFT have proven through research and studies that they are two of the most effective programs. If other programs in the juvenile justice system followed their models, they could be just as successful.

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