Overview of the FIT Treatment Model

It is estimated that 65-70% of youth in the juvenile justice system have a mental health diagnosis, and approximately 20% have a serious mental health disorder (Teplin et al. 2002; Cocozza & Skowyra, 2000). Juvenile justice systems in the United States are recognizing the need to treat mental health concerns among youth detainees to reduce the risk of recidivism and improve the overall well-being of detained children. When youth receive treatment while in an institution, their adaptive functioning may increase; however, youth may face difficulties in maintaining these gains when they are released. As they return to their communities, they may face a variety of risks that challenge their ability to maintain sobriety and avoid illegal behavior. These risks include troubled family environments, exposure to friends or family members who use substances or engage in illegal behaviors, unstructured time, problems with school or occupational performance, and lack of reinforcement for improved behavior. Research supports the importance of providing support during this critical transition period (Bullis et al., 2002; Trupin et al., 2004).

Family Integrated Transitions (FIT) provides integrated individual and family services to juvenile offenders with mental health and chemical dependency disorders during the period of the youth's transition from incarceration back to the community. The goals of the FIT program include lowering the risk for recidivism, connecting the family with appropriate community supports, achieving youth abstinence from alcohol and other drugs, improving the mental health status of the youth, and increasing prosocial behavior. FIT has been implemented in four counties in Washington State (King, Pierce, Snohomish, and Kitsap) by two clinical provider teams, and has provided an unprecedented level of service to youth who are among the most difficult to treat in the juvenile justice, chemical dependency, and mental health treatment systems.

The FIT approach combines three evidence-based interventions with the goal of targeting multiple determinants of noncompliant behavior. The overarching framework of the intervention is derived from Multisystemic Therapy (MST), a scientifically-validated, cost-effective, intensive family preservation model for community-based treatment that has been shown to be effective with youth with noncompliant behaviors (Henggeler et al., 1998). Intervention targets the various systems that are involved with the child, including family, peers, schools, probation/parole, and other community supports, in order to create an environment that supports positive behavior in the long term. Because caregivers are recognized as the key to the youth's long term success, MST strongly emphasizes parents' empowerment, both within systems that affect their families and in relations with their children. Therapists coach caregivers in establishing productive partnerships with schools, community supports, parole, and other systems;

and help caregivers develop skills to be effective advocates for their children. Therapists also work intensively with parents to bolster their family management skills, including monitoring, contingency management, conflict resolution, and relationship enhancement. The objective is to help the parent create a home environment that holds the youth accountable for his/her behavior and that makes prosocial behavior more rewarding than antisocial behavior. The University of Washington is an MST Network Partner, and the standard MST fidelity and quality assurance procedures are incorporated into FIT. One difference is that FIT provides monthly booster training sessions for FIT therapists and supervisors, whereas standard MST provides booster training quarterly. Other non-MST treatments used by FIT (described below) are also topics for booster sessions.

MST focuses on increasing the extent to which environments around a youth support prosocial behavior. However, a youth's own skills and capacities must also be bolstered if he or she is to be successful in the community. Poor impulse control, anger management problems, mood swings, and other types of emotional and behavioral dysregulation are hallmark symptoms of a range of mental health diagnoses common among youth in the juvenile justice system. These problems are often primary contributing factors to a youth's criminal behavior, poor functioning at home and in the community, and substance use. Emotional dysregulation within a family can also have an indirect effect on the youth's behavior, since such problems can interfere with a parent's ability to effectively monitor a youth, consistently implement contingency management plans or maintain a warm, caring relationship. Recognizing that enhancing the ability of both the youth and the parent to manage impulses and distressing emotions is pivotal to a behavior intervention, FIT incorporates elements of Dialectical Behavior Therapy (DBT) into the intervention. DBT is an empirically validated treatment designed to replace maladaptive emotional and behavioral responses with more effective and skillful responses. Clients are taught a series of skills that enhance the capacity to monitor emotional states, control emotional arousal, tolerate distress, and interact with others in a more effective manner (Linehan, 1993). In Washington State, DBT skills are taught to youth who are incarcerated in Juvenile Rehabilitation Administration facilities. FIT therapists build on the skills that youth have acquired in the institution and coach youth in using these skills in real-world settings. Therapists also teach these skills to parents so that parents can both use these skills themselves and support the youth in maintaining the skills in the long term. A DBT consultant participates in the weekly telephone consultation to the FIT teams, and provides DBT booster sessions.

Engaging and retaining families in treatment by enhancing their motivation to change is a cornerstone of the FIT intervention.

Youth involved in the juvenile justice system and their families are often reluctant to participate in therapy and have a high probability of dropping out of treatment. Even if a family enrolls in and completes treatment, treatment is unlikely to have lasting positive outcomes if the family is not committed to change. Thus, engaging and retaining families in treatment by enhancing their motivation to change is a cornerstone of the FIT intervention. FIT relies heavily on the engagement techniques of Motivational Enhancement Therapy (MET), an approach developed by Miller and Rollnick (1991) to engage clients in treatment with the objective of increasing their commitment to change. It is a focused and goal-directed approach, with the overarching objective of helping clients to explore and resolve ambivalence about change. In FIT, change happens at several levels: the parent's monitoring and contingency management practices; the parent's and the youth's interactions with the school, peers, and the community; the youth's criminal behavior and substance use; and the parent's and the youth's ability to regulate emotions, tolerate distress, and interact with others in a respectful, effective manner. All of these changes require sustained effort and commitment if they are to be maintained in the long term. The FIT therapist uses MET techniques to develop initial engagement of all parties (the youth, parents, school personnel, probation officer, and others) and to maintain commitment to the changes that are being made. MET permeates every aspect of the FIT intervention.

Regional Research Institute for Human Services, Portland State University.
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FIT ELIGIBILITY CRITERIA

1. Any youth 17 ½ years or younger, being released from a Washington State Juvenile Rehabilitation Administration residential commitment to four months or more of parole supervision; WITH

2. Any Substance Abuse or Dependence Disorder; AND

3. Mental health concerns as evidenced by:

a. any AXIS 1 Disorder (excluding those youth who have only a diagnosis of Conduct Disorder, Oppositional Defiant Disorder, paraphilia, or pedophilia) OR

b. currently prescribed psychotropic medication, OR

c. demonstration of suicidal behavior within the last three months, AND

4. Residence in one of the counties currently served by the program (King, Pierce, Snohomish, or Kitsap).

Youth and families who participate in FIT are assessed to determine their unique treatment needs, and services are tailored to meet those needs. Treatment focuses on family strengths, and goals are set by the family. Services are provided in the family's home with a minimum of one scheduled appointment per week. Therapists are available on a 24-hour-per-day, 7-days-per-week basis to respond to crises and provide between-session skill coaching by telephone as needed. Treatment begins approximately two months before the youth is released and continues for a total of approximately six months.

Outcome Evaluation

In 2004, the Washington State Institute of Public Policy (WSIPP) released a report on the criminal outcomes and cost effectiveness of the FIT program (Aos, 2004). Youth who received FIT services were compared to a matched comparison group who resided in counties not served by the FIT program but otherwise met FIT eligibility criteria. At 18 months post release, felony recidivism was 34% lower for FIT clients (27%) than for comparison youth (41%), a statistically significant difference. A cost-benefit analysis indicated that for every dollar spent on the FIT program, $3.15 is saved in criminal justice expenses and avoided criminal victimizations.

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Terry Lee is Acting Assistant Professor at the Division of Public Behavioral Health and Justice Policy at the University of Washington Department of Psychiatry and Behavioral Sciences. He is interested in the development, implementation and dissemination of evidence-based practices.

Megan De Robertis is a research coordinator in the same Division. Her interests focus on prevention and cognitive-behavioral interventions with at-risk youth.

For more information about Family Integrated Transitions, please contact Eric Trupin at (206) 685-2085 or trupin@u.washington.edu