

*Abstract*

The widespread fear over youth violence in media coverage in recent decades has brought renewed public interest to why such atrocities are taking place and how we can prevent it. School shootings, drug abuse, and criminal behavior are common. There have been many stipulations and assumptions about what should be done and what is not being done, but these notions mostly deal with confining the culprits and dealing with the cases as individual occurrences, such as school shootings. Researchers are coming to a consensus that in order to prevent delinquency overall analysis of the situation and effective prevention programs must be in place to help these youths. The Office of Juvenile Justice and Delinquency Prevention suggests three important factors in preventing violence: understanding the characteristics of at risk youth, developing and implementing programs to overcome risks factors, and promoting protective factors to maintain effectiveness.

The overall purpose of this paper is to review the functionality of treatment programs and their characteristics. However, the main focus of this paper is the review of Multisystemic Therapy (MST) and the widely implemented Intensive Diversion Delinquency Service (IDDS) program, which have been developed based on MST.

*Literature Review*

For the past several decades adolescent behavior has become more violent and disruptive, developing into a grave concern for parents and political officials. Media coverage frequently shows footage of violent crimes committed by younger and younger children. Even though there has been an overall decrease in violence, deadlier shootings are becoming more frequent. Increase in media coverage perpetuates violence, as well, and skews statistics of adolescent violence (Amato, 2005). The Office of Juvenile Delinquency Prevention reports that the juvenile crime arrest rate has declined even though there was a growth in juvenile population. This is a comfort for those who are unfamiliar; however, violent crime rates in the United States are much higher than many industrialized countries (Fagan, 1995).

The current policy in responding to youth violence and crime prevention by government officials and juvenile justice agencies is immediate and punitive punishment. Popular metaphors used by policy makers to incite support in responding to youth crimes have been about waging battle against violence and antisocialism, for example “get tough on crime” and “fight against violence” (Rine, 2004). These emotionally stirring slogans suggest that the only way to prevent and reduce delinquency is through punishment instead of teaching adolescents how to make better decisions and how to cope with change and stress (Rine, 2004).

During the 1990s, youth homicide rose drastically, causing an epidemic in youth violence. Because of the widespread fear and disruption, well to do policy makers incorporated corporal like punishment that seemed fit for military discipline and prison

control rather than juvenile delinquency. In addition to the tough policy reform, the costs associated with these programs are actually more than many adult programs (Rine, 2004).

Traditionally, treatment efforts are the last step before detention or institutionalization. As research continues to advance, more data suggests that therapeutic treatments are the more effective strategy toward reducing juveniles' antisocial and violent behavior. However, it is hard to persuade a society that is used to instant gratification and immediate results to use this strategy. The relationship between therapy and improved behavior is much harder to prove when comparing treatment programs to detention programs that confine delinquents so that they do not commit more crimes (Taylor, 2004).

The nature of a criminal justice agency is the same as any other government agency; it is slow acting and non-responsive until there is a public outcry. Changing public perception and that of government agencies require empirical data and proven results. Since many juvenile delinquency detention programs, corporal punishments, and rehabilitation techniques are not producing positive results, agencies are forced to look for alternative methods. These agencies' attentions are now focused on validating data and proactively reducing youths' antisocial and violent behavior (Farrington, 2004).

The purpose of this paper is to review the nature of various common types of antisocial and violent behavior and therapeutic prevention programs. Some of the identified programs that have gained recognition are Functional Family Therapy (FFT), Life Skills Training (LST), and Big Brothers Big Sisters of America (BBBSA). The two particular programs of interest are Multisystemic Therapy (MST) and Intensive Delinquency Diversion Services (IDDS). The center piece of this paper is to reflect on

IDDS based on my experiences as an IDDS counselor. The empirical data for MST are undeniable but the results and expectations for IDDS have never truly been clarify.

### *Delinquent Behavior*

Delinquency used to mean unacceptable behavior by young people. Today', it would also include having committed criminal acts and having been through the judicial process. Juvenile delinquency refers to criminal acts performed by juveniles (Merriam-Webster, 2007). It has been established as having core behavior that is negative. Typically, juvenile delinquents are divided into smaller categories; however, there is little clarity in what this entails. The two general definition of delinquent are behavior restricted by law and behaviors perceived as unacceptable; this paper only deals with delinquency as restricted by law. Drugs and crime are considered to be the core problems of behavior restricted by law. Drugs and crime are risk factors, not causal factors, indicated in majority of longitudinal studies of delinquency. Because these risk factors don't necessarily produce cause delinquency, they cannot be considered causal factors.

Drugs use and crime are antisocial and violent behaviors which contribute to large part of delinquency. Antisocial behavior is identified as a "psychiatric condition characterized by an individuals' disregard for social norms, rules, and codes of conducts, in conjunction with impulsive behavior, and indifference to others' feelings" (Merriam-Webster, 2007). Two dimensions of this behavior are internalization and externalization. Internalizing disorders are directed inward, which includes withdrawal, isolation, and depression. Externalizing are directed outward, which includes verbal and physical aggression, acts of violence, and disturbing others. Violent behaviors are physical attacks and life threatening use of drugs with the intent to cause damage and injury.

Externalizing behaviors are the most recognizable behaviors and are the subject of many therapeutic and intervention programs. Public attention to these behaviors arises because these behaviors cannot be ignored. Unlike internalizing disorders, externalizing disorders are associated with the criminal court or the juvenile justice system. Once a youth has been through the justice system, he/she is labeled as juvenile delinquent. A juvenile delinquent is a person under the age of 18 who has committed an illegal act (Merriam-Webster, 2007). The majority of the illegal acts committed by juvenile delinquents are non-violent crimes. The biggest factor behind violent crime is the availability of fire arms.

Young people with internalizing behavior disorders are just troubled, but they rarely disturb others and are often overlooked, which means they won't receive treatments for their problems. Some do eventually get better, while others display signs of externalizing behaviors, such as suicide and targeted violence. Suicide is one of the leading causes of death among adolescents (Alexander et al., 1998). According to the Center for Disease Control and Prevention, the suicide rate jumped to record highs from 1980 to 1997 for the ages of 10 through 14 years old.

Targeted violence incidents by youth are rare; however, because of the massive proportion of media attention, it is one of the largest concerns for parents and school officials. Unlike other behavior disorders, the secretive nature of targeted violence makes it extremely difficult to prevent or monitor. The best way to circumvent or divert these types of behaviors is to monitor the risk factors and the conditions in which they occur. Understanding risk factors helps explain youths' development of antisocial and violent behavior (Alexander et al., 1998).

*Behavior Risk Factors and Protective Factors*

Risk factors are defined as any youth who has a disabling condition, whether is it from economic, cultural, medical condition, and is in jeopardy of becoming a delinquent member of his/her community. These risk factors affect everyone at one point or another in their lives and depending on the severity and duration can adversely affect individual development. The combination of these risk factors increases the probability of delinquency, especially during youths' vulnerable developmental years. Risk factors are categorized into internal and external risks. Internal risks are individual physical and psychological characteristics. External characteristics are family, friends, school, and community (Fagan, 1995).

The opposite of risk factors are protective factors. Protective factors are also divided into internal and external categories. Internal protective factors are characteristics that help a person make appropriate choices in the presence of risk factors. These characteristics are resiliency, cognitive competency, stress coping mechanisms, interpersonal skills, and conflict resolutions. External factors on the other hand are the individual environments, which are adolescent's school, home, and community. A supportive family and social structure can help eliminate many risk factors (Alexander et al., 1998). If adolescent's social structure is one of the causal factors for delinquency then immediate intervention is needed.

Intervention works best when it is applied at the appropriate time and place in order prevent and divert antisocial and violent behavior in delinquency. As a result, practitioners advocate prevention of delinquency at the beginning of a child's negative

exposure to stimuli (Fagan, 1995). Multiple internal and external protective factors are typically chosen for youths who exhibit at risk behavior.

#### *Delinquent Intervention/Prevention Programs*

The various approaches used for addressing youths' delinquency have been classified as either reactive or proactive techniques. Reactive approaches consist of treating the problem after it has been diagnosed. Proactive strategies deal with preventing delinquency before it is fully manifested. Practitioners' main objectives for preventing delinquency and at-risk behaviors are to foster protective factors and intervene at the appropriate time. The main variable in choosing intervention or prevention programs is empirical support. The difficulty with good programs is that they are not supported by enough empirical data, while well funded programs are repetitively used because they have empirical support (Fagan, 1995).

An additional part of many intervention, prevention, or diversion programs is individual and/or group psychotherapy. The empirical data for psychotherapy is inconclusive. Perhaps the most compelling argument for using empirically proven programs to prevent crime is that they categorized youth offenses more harshly than they should have been (Farrington, 2004). With these classifications and labels, it is easier to implement tough social policies for troubled youths.

#### *Effective Intervention/Prevention Programs*

To be effective at addressing youths' delinquency, administrators must focus on pinpointing the traits that need to be addressed and applying it to the programs that have successfully produced results. Many counties and schools do have some sort of prevention programs; however, they typically lack empirical support and are easy to use

because they are cheap to implement (Farrington, 2004). As a result, the Center for the Study and Prevention of Violence (CSPV), the Office of the Surgeon General, the American Federation of Teachers (AFT), and many others have identify several programs that meet the standards for reducing delinquency.

The standards provide a practical detail of effective programs and implementation, such as cost estimates for intervention, assessment for success, and the calculated barriers and obstacles for implementation (Alexander et al., 1998). The programs that produced the most recognition are Functional Family Therapy (FFT), Life Skills Training (LST), Big Brothers Big Sisters of America (BBBSA), Multidimensional Treatment Foster Care (MTFC), Promoting Alternative Thinking Strategies (PATH), and Bullying Prevention Program. The two programs that produce the most comprehensive benefits are Multisystemic Therapy (MST) and Intensive Delinquency Diversion Services (IDDS). Each of these programs is unique in its own way and is the product of the latest empirical research, trial and error, and constant revision (Alexander et al., 1998). All of these programs work best when they are combined to serve the needs of the youths and their families. In addition, these programs are approved by the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

#### *Functional Family Therapy*

Functional Family Therapy (FFT) is a family-based prevention and intervention program that has been implemented successfully across a wide range of high-risk youths and their families. FFT has been recommended as one of the great example of family-based treatments for delinquent behavior according to Mendel, Sexton, and Alexander. FFT was developed in 1969 at the University of Utah's Psychology Department Family

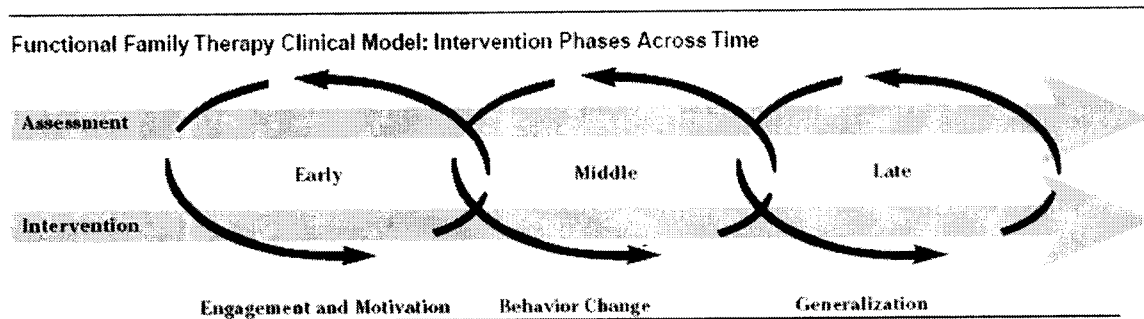
Clinic to help at-risk adolescents and their families (Alexander et al., 1998). Before the development of FFT and similar programs, most family based programs were undeveloped and untested, while the rate of delinquency, violence, and drug abuse were escalating at a dismal rate.

Even though FFT is typically used as an intervention program, it can also be used as a prevention program for at risk youths. FFT is a multi-dimensional program because it includes diversion, probation, and reentry programs for youth adaption to the community. Because of its high success rate, FFT has been selected as a “blueprint program,” an “exemplary model,” and a “family based empirically supported treatment” (Alexander et al., 1998). The core purpose of FFT is to identify and intervene in the positive and negative behaviors that are influenced by multiple relational systems. FFT is also considered as a multisystemic prevention program due to the wide ranges of responses offer to adolescents and their families.

During the 1990’s, the Functional Family Therapy-Clinical Service System (FFT-CSS) was developed. This extraordinary development had been made to refine the phases of intervention; training and development of implementation program; and a comprehensive client, process, and outcome assessment system. FFT-CSS helps clinicians identify and evaluate outcome as well as accountability of intervention programs.

The most important aspect about FFT is that it helps family members build upon their inner strengths or protective factors, so that they have the strength to improve their situations. The basis for change and future functioning depends upon the therapist’s

support and careful assessment. In order to systematically manage families treatments, clinicians have developed an intervention map or a Phase Task Analysis.



Sexton & Alexander (2000)

The intervention phases consist of three specific phases. Engagement and motivation, behavior change, and generalization are interrelated and sequentially linked. Like most therapeutic programs, the introductory phases clarify and resolve any misunderstanding patients might have about the program, in addition to enhancing the program credibility. During the second phase, clinicians help families develop and implement short term, as well as, long term behavior modification plans. In the final phase of intervention, clinicians guide changes and behavior modifications to other problem areas, help maintain changes, and help prevent relapses (Sexton & Alexander, 2000).

The assessment is a continual process designed to support each phase of intervention. The goal of the assessment is to focus on the families' adaptive responses, identify risk factors, protective factors, and individual factors, improve functioning factors, and evaluate clinical outcome. These characteristics of the FFT-CSS help improve therapists' understanding and recognition of problem signs and adapt intervention programs based on the needs of the families.

### *Life Skills Training*

Life Skills Training (LST) is a substance abuse and violence prevention program for youths from 11 to 14 years of age. The program provides adolescents with skills necessary to resist social pressure to use drugs and alcohol, which includes developing their self esteem and self confidence, helping them cope with stress, and increasing their cognitive abilities in order to have good decision making skills.

LST was introduced in the early 1980s, based on the Life Skills model of preventing substance abuse. The basis for LST is that drug abuse is the result of the dynamic interaction between a person and his/her environment. The program's initial focus was on preventing cigarette smoking in middle-class Caucasian youths. Due to its success, LST has extended its involvement into other racial classes and substance abuse. LST has been identified as a model program by various organizations, such as the Center for the Study and Prevention of Violence (CVSP); The Safe, Disciplined, and Drug-Free Expert Panel; and the Surgeon General report (Life Skills Training online, 2007).

LST classes are in a three years program, which run from 15 minutes to 45 minutes and are implemented during 10 to 24 class sessions. LST classes are completely independent of school curriculum and are a self contained prevention program. To implement the class, all that a school needs is a Life Skills trained instructor, instructional manual, student guide, and a relaxation tape. The main focus of the program is to inform and educate students about the hazards of drugs, good decision making skills, and general social skills. Despite its simplicity, LST has consistently proven to reduce tobacco, alcohol, and marijuana use. Post evaluation also showed long-lasting success with a wide range of youths in abstaining from alcohol and drugs (Life Skills Training online, 2007).

*Big Brothers Big Sisters of America*

Big Brothers Big Sisters of America (BBBSA) was founded by Earnest Coulter in 1904 as a community based mentoring program. The original purpose was to help decrease the number of delinquent youths who came before the courts. As times changed, BBBSA became more focused on preventing delinquency by providing support for youths in coping with social stress and pressure. The program's main objective is to improve youths' social behavior, academic achievement, and relationship with family and friends (BBBSA online).

The adult volunteer is called a Big Brother or Sister and the child is called a Little Brother or Sister. A case manager oversees the process of selecting, monitoring, and closing the match between a youth and his/her mentor in conjunction with communicating with the youth's parent/guardian about the child's progress.

In order to maintain an up-to-date work flow, GoldMine was chosen to monitor the development of relationships between volunteers and youths. GoldMine's appeal was that it enhanced the existing database, needed minimal supervision, and increased flexibility. The Community Relations Department uses GoldMine to connect with its youths and volunteers via email to schedule different activities. In addition, GoldMine also keeps a record of active and inactive volunteers. GoldMine is the main program for BBBSA in the United States; however, in other countries BBBS may use a variation of other GoldMine software (BBBSA online).

Even though the BBBSA may seem simple, it has produced some of the most astounding results. Researchers have shown a measureable lasting benefit between the youth and the adult (BBBSA online). The one-on-one relationship mentoring program

helps kids overcome many challenges such as peer pressure, drugs, and alcohol abuse. Overall, the program helps youths with developing a greater self-esteem, greater social confidence, improvement in schoolwork, and a better outlook on life.

## Multisystemic Therapy & Intensive Delinquency Diversion Services

### *Multisystemic Therapy*

Multisystemic Therapy (MST) was developed because of the violent and chronic juvenile offenders who seem to resist treatment from other programs. Like FFT, LST, BBBSA, most other prevention/intervention programs only deal with a specific factor of the youths' disorders or their families' dis-functionality. Single factor programs, such as BBBSA are extremely helpful in promoting self outlook; however, it can be difficult to prevent delinquency when so many other factors simultaneously affect the youths. The MST approach addresses the multidimensional and dynamic nature of adolescent behavior disorders through community based treatment programs (Medical University of South Carolina Online, 2007), which focuses on the youths and their families/support systems (Henggeler et al., 2002).

MST is a home based treatment program that offers to change youths' behavior in their natural environments, such as school, home, and neighborhood (Medical University of South Carolina Online, 2007). The MST approach views individual as being connected by a social network. In order for a change to occur, the social network must be altered. The intent of using a home-based system to deliver MST is to intervene where and when the treatment is needed to modify a youth's natural ecology in a way that will

avert criminal behavior and future foster care placements. Based on MST philosophy, the biggest support system for youths is their parents (Henggeler et al., 2002). Parents are valuable resources in helping their children to abstain from antisocial and criminal behaviors. The goals of MST are to reduce youth criminal activity and antisocial behavior, such as drug abuse, and to decrease the rate of incarceration (Henggeler et al., 2002).

The MST process uses an ongoing systematic assessment and treatment process to encourage clinicians to produce a hypothesis about the combination of problem factors that a youth and family might have in order to recommend intervention treatments. MST effectiveness is based on its nine treatment principles and analytical process to enable therapists to understand, prioritize, and address the complexity and dynamics of the youth's emotional disturbances (Henggeler et al., 2002). Unlike other treatment programs, MST therapists individualize the strategies and treatment process to capitalize on the strengths and weaknesses of the youth, friends, family, and the surrounding environment (Medical University of South Carolina Online, 2007).

MST nine treatment principles are based on "treatment specification" or the process of translating treatment ideas into implementable actions to effectively manage behavior disorders (Henggeler et al., 2002). An important aspect about MST treatment principles are that they are consistent with empirically based treatment used for cognitive behavior therapies. Listed on the next page are the nine treatment principles. These principles are self explanatory and are fitted onto a business card for easy reference and clarification of the program purpose.

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*MST 9 Treatment Principles*

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*Principle 1:* The primary purpose of assessment is to understand the “fit” between the identified problems and their broader systemic context.

*Principle 2:* Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.

*Principle 3:* Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.

*Principle 4:* Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.

*Principle 5:* Interventions should target sequences of behavior within and between multiple systems that maintain the identified problems.

*Principle 6:* Interventions should be developmentally appropriate and fit the developmental needs of the youth.

*Principle 7:* Interventions should be designed to require daily or weekly effort by family members.

*Principle 8:* Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.

*Principle 9:* Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members’ needs across multiple systemic contexts.

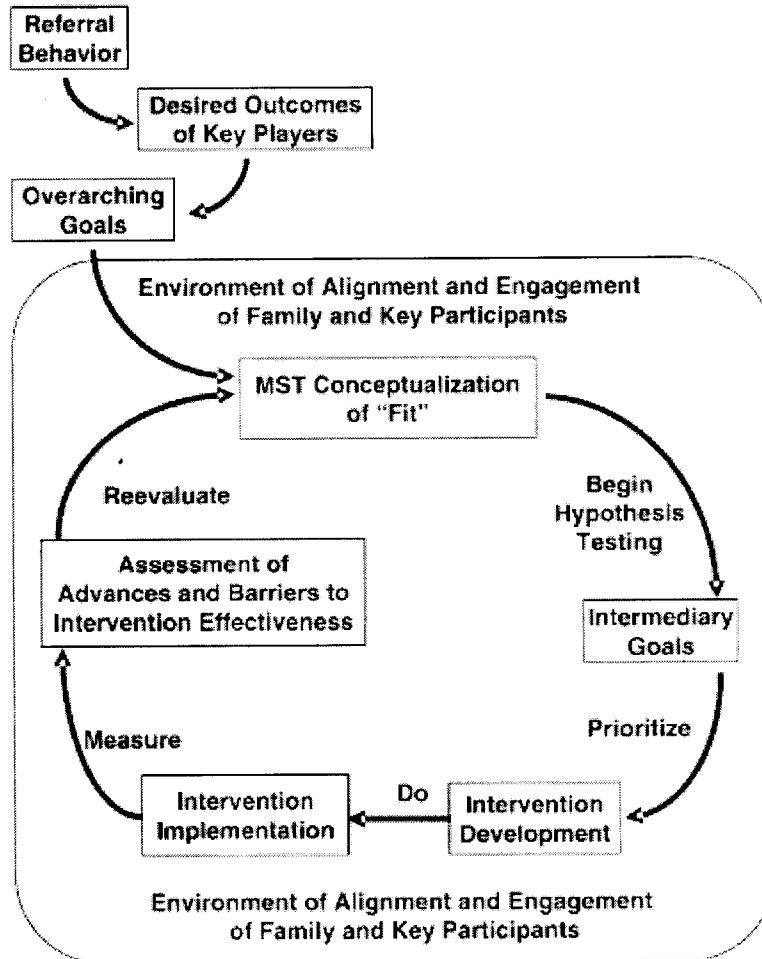
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(Henggeler et al., 2002)

In addition to its nine treatment principles, the analytical process combined the steps and phases of the identified problem assessment with the development and implementation of the interventions process. Using the analytical process as a foundation, a weekly summary report is completed at the end of each week by clinicians to assess treatment progress. The Analytical Process below identifies the steps clinicians

take to draw a hypothesis about the problem behaviors using knowledge based on the individual, family, friends, school, neighbors and self reports (Henggeler et al., 2002).

*MST Analytical Process (Do-Loop)*



(Henggeler et al., 2002)

To deliver MST home-based treatment programs, MST therapist must be a highly competent professional with at least a bachelor degree. Therapists operate in a team between two and four plus a supervisor. MST caseloads often do not exceed six families per therapist. MST therapists are available twenty four hours a day for time of crisis and

intervention. The expected duration of the program is about three to five months (Henggeler et al., 2002).

### *Intensive Delinquency Diversion Services*

Based on MST effective intervention techniques, Intensive Delinquency Diversion Services (IDDS) deliver the same services with a portion of the costs to the community. IDDS is an alternative to formal court involvement and supervision for high-risk youths. Like most intensive diversion programs, IDDS goals are to protect the public, reduce recidivism, and increase responsible productive behavior (University of West Florida Online, 2007). IDDS is designed to serve juvenile offenders referred by the Department of Juvenile Justice (DJJ). The focus is on high risk youths who are at risk of becoming serious or chronic offenders. In order for youth to be admitted into an intensive diversion program, youth must be recommended by the state attorney, have school behavior and family problems, have substance abuse issues, exhibit high risk pre-delinquent behaviors, and be less than 16 years of age at the time of offense (University of West Florida Online, 2007).

Service delivery involves a holistic approach in working with both the youth and family. Services include but are not limited to the following: parenting skills training, social/life/ self-sufficiency skills enhancement, mental health and substance abuse counseling, education/academic assistance, and pre-vocational services. Transportation is provided or arranged for the youth and family to meet sanctions/services (University of West Florida Online, 2007).

Supervision is from five to seven months and includes the following contact requirements:

- Two face-to-face surveillance type contacts with each youth per week
- One face-to-face treatment contact with each youth per week
- One face-to-face treatment contact with the parent/guardian of each youth per week
- One face-to-face contact with the guidance department of the youth's school per week
- One contact (may be by telephone) with each entity providing service to the youth

An integral part of the program is the establishment of an appropriate connection with local services that can provide services at a reduced cost. The length of the program is typically between five and seven months. Release from the program is entirely based on youth and family's cooperation and performance in the program.

Like MST therapists, IDDS counselors must have at a bachelor degree and be working toward a master degree in clinical psychology, legal study, criminal justice, and related majors. Before an IDDS counselor can even go out to the field with a senior counselor he/she must have completed their 20 hours core online training, Protective Action Response (PAR) course and be First Aid and CPR Certified (University of West Florida Online, 2007).

After approximately two to three months of training, the new IDDS counselor is then allowed to shadow senior counselors for about a month and a half. The required shadow typically consist of three house visits, three school visits, one court appearance, one DJJ community meeting, and one DJJ county headquarter visit. On the next page is a

condense list of guidelines designed to help IDDS counselors service their youths and families, as well as following DJJ strict procedure.

- The supervisor has 24 hours to assign the youth to a counselor after the youth has been assigned to IDDS.
- Non-clinical evaluation commences within 3 working days of admission.
- The counselor's first face-to-face contact with the youth is within 7 days of the assignment to the case. During the case opening, the counselor must explain the program; explain the exceptions and requirements, complete the initial service packet, perform a needs assessment, develop an original service plan, and explain the initiation of Children's Functional Assessment Rating Scale (CFARS).
- Field notes or documentation of each contact is kept up to date using codes and basic demographic.
- Needs assessment is conducted within 10 working days of admission to program.
- Service plans are done every 30 days or as revisions are needed for the supervisor, the IDDS counselor, the parents, and the youth sign service plan.
- Service plans are individualized and based on the identified and prioritized needs.
- Service plans document that the youth and parent are involved in the development of the plan.
- Service plans also implement mental health, substance abuse, and preparation for independent living if noted in needs assessment, Treatment Assessment Service Center (TASC), or Psyche evaluation.

- Social skills enhancement, self sufficiency, and life skills must be taught to client by counselor or other provider.
- Education and academic assistance consists of homework assistance, tutoring, mentoring, and testing services.
- Program must develop, recruit, and maintain available worksites for youths to do community service.
- A valid post test must be taken at the time the youth is successfully released from CFAR.

#### *Analysis/Recommendations*

The documentation and requirements for IDDS counselors listed above are just a few items that needed to be done in order to comply with the Department of Juvenile Justice. It may seem strenuous and can certainly be for new IDDS counselors; however, once a routine has been developed it can be manageable. The main concern for most IDDS counselors is whether they are making any differences at all. As was stated previously, IDDS is a simplified form of MST, but it has neither been supported nor disproved by empirical data. In a sense, IDDS is braving uncharted water in the field of delinquency diversion. MST's sole purpose is to identify and treat delinquent behaviors; however, IDDS's purpose is to monitor and recommend treatment programs. Unlike MST, IDDS treatment teams do not have to include parents and youths.

MST is a home and community based treatment service program (Medical University of South Carolina Online, 2007); however, much of IDDS is about surveying and monitoring youths' sanctions. The treatment process by MST is serviced by four to six well trained professionals; on the other hand, IDDS counselors typically work alone

and on occasion with a senior counselor. Similar to MST, the purpose of the IDDS service plan is to reduce risk factors and strengthen protective factors. In every aspect, IDDS counselors do make some differences in youths' lives. The level of benefits and changes however are unknown. The biggest problem with the service delivery of IDDS counselors are that they mainly monitors, documents, and finds community service programs, instead of actual counseling services like MST counselors. MST counselors perform several hours of counseling per week (Medical University of South Carolina Online, 2007).

IDDS counselors do not actually perform therapy because we are not authorized or certified to perform these services. We are authorized to recommend sanctions, treatment plans, and life skills education, but we may not perform psychotherapy counseling, diagnose problems, and treatments of any kind. In this regard, IDDS counselors are powerless to influence their clients in behavioral changes. IDDS counselors therefore do not counsel at all, instead they mediate and help families navigate through the juvenile judicial system.

Although a large part of an IDDS counselor's work load is documentation and following DJJ procedures, it lacks formality and structure. Due to the nature of the visits and the cooperation required from the families, counselors are constantly nagging and pestering parents and youths to comply with the state attorney requirements. IDDS counselors can advise families to take steps in completing their sanctions and meeting DJJ requirements but they rely solely on the Juvenile Probation Officers to enforce any regulations. Even if youths violate their probations by getting expelled, staying past their

curfews, and not showing up for random urinary analysis, IDDS counselors can only document it and report it to their supervisors and JPOs.

The most frustrating characteristics about this position are that even though we deal directly with the families and their problems, we are powerless to personally intervene and console them. Often time, the home visits that we schedule with the families are ignored because we are unable to have direct influences in their lives. And in return they would not be home when we come. The problems that we face as IDDS counselors are numerous; however, the biggest issue is our feeling that we cannot to make any significant changes in our clients' behavior.

The changes that need to occur in order to retain counselors are better on the job training, which does not include spending countless hours of online core training, and obtaining counseling certificates that would allow counselors to do more for their clients. In addition, an IDDS service team must include the counselors who are involve with the families, as well as, a family member of the client. Direct interaction between service team and clients are crucial in order to accurately recommend treatment plans.

Even though most counselors are well familiar with treatment plans and documentation procedures, the overall goal and expectations are sometime unclear and ambiguous. Counselors must sit down with their supervisors and/or service team and discuss the treatment plans for the youths and families before and after the initial visit. The IDDS mission is a great one; however, it's over arching goals are too vast to be followed without step by step procedures. The IDDS mission is not difficult to understand and implement; however, because counselors come from different career tracks, ambiguity and personal experiences distort IDDS real agendas.

Like any other public service professions, IDDS counselors must know what is expected of them and the steps they need to take to perform it. Is closing a youth considered a job well done, or is it making an impact on the youth after he/she has completed the program? What are the measurements of success and failure? What are the criteria for evaluating an IDDS counselor? How is IDDS measuring up to the standards of MST?

As an IDDS counselor at University of West Florida Department of Juvenile Studies, I have gained a tremendous amount of field knowledge and experiences. The work that IDDS counselors perform is no doubt invaluable; however, without the credentials it can be disregarded and undermined. Despite strict requirements from the Department of Juvenile Justice, the IDDS program lacks structure and consistency due to high turn-over rate and lengthy training procedure.

#### *Summary and Conclusions*

Even though FFT, LST, and BBBSA are excellent programs, they do not cover all of the requirements of youths and families as part of the dynamic of their daily life. Even more important than the program is the behavior modification and skills that youths and families learn after they have completed their programs. The best program can be of no use if it has zero retention rates for its clients. One of the main focuses of these programs is to help youths and families become more resourceful in dealing with stress, peer pressure, and negative stimuli.

The two most important factors clinicians and counselors must be constantly aware of are the risk and protective factors. These factors are carefully examined by MST clinicians and IDDS counselors, but it does not mean that they are continuously

conscious of every youth's minute strengths and weaknesses. In order for us to reduce delinquency, every program must have a clear grasp of the main objective and work with its community partners. Community partnership is the best solution to reducing delinquency because of the variety of expertise and resources it offers.

Besides understanding youth's strengths and weaknesses, it is also important to let them know that someone does care. As cliché as it may sound, during youths developmental stages, mentoring and caring may be the most important part of a clinician/counselor's job description. In addition to being a good friend, availability is another important aspect for maintaining a good relationship with the youths and families. MST and IDDS do this well; however, if there were more similar programs then we would definitely see a continuous decrease in delinquency.

Overall, the complex nature of a youth's antisocial and violent behavior defies simple solution; however, with the current collective knowledge of our judicial system and psychiatry we can prevent and intervene to reduce future criminal activity. Longitudinal research has termed antisocial and violent behavior as life-course trajectories with risk and protective factors influencing throughout the process. Antisocial behavior is a pattern beginning with minor misconduct and progressing to criminal or violent behavior. As a result, prevention strategies work best when they are implemented early, learned, performed, and maintained in the youth's daily routines.

One of the most disconcerting aspects about our grant funding system is that it promotes competition. Despite the urgency and careful planning placed on decreasing youths' antisocial and violent behavior, programs fight for government funding on a regular basis. Without cohesion and cooperation among community programs, families

and youths will be pushed and pulled until are tire of trying. The best solution will take more than the winner take all strategy of obtaining grant funding. Community partnership in addition to longevity will enable its clinicians/counselors to dedicate the time and energy needed to fight this up-hill-battle. Delinquency is a community problem and it will take the entire community to effectively reduce and prevent it.

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