

# Helping Juvenile Offenders on Their Own “Turf”: Tracking the Recidivism Outcomes of a Home-based Paraprofessional Intervention

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## Abstract

As a problem that leads to many burdens on families and communities, juvenile delinquency has prompted much attention and many types of interventions over the years. Despite great efforts and noted progress in helping some adjudicated offenders, recidivism continues to be a substantial problem for others. Budgets continue to tighten, so finding ways of addressing juvenile delinquency more effectively (and reducing recidivism in particular) become even more important. Realizing this, the Utah Juvenile Court recently conducted a study of all its contracted programs aimed at reducing recidivism. Among the program effects observed, in-home interventions using paraprofessional workers showed striking and unique results. This article reviews these evaluation findings and considers several reasons why an in-home approach may be especially effective for reducing recidivism.

## Introduction

Although the juvenile arrest rate has declined over the last decade and a half, criminal misconduct among youth continues to be a concern in the United States (Office of Juvenile Justice and Delinquency Prevention, 2011). While preemptive action to reduce the likelihood of crime still remains the best investment of resources, the demands of youth already in the system mean that most efforts go toward rehabilitation. In cases in which a youth has already committed a crime, the natural goal is to help ensure it doesn't happen again, through a "criminal desistance" process by which a person arrives at a permanent state of nonoffending (Bushway, Piquero, Broidy, Cauffman, & Mazerolle, 2011). As measured in various ways, recidivism has thus become an increasingly important benchmark of effective juvenile offender programming (National Institute of Justice, 2011; Stojkovic, Klofas, & Kalinich, 2010).

Given the variability in measurement approaches and state system characteristics, local juvenile recidivism rates vary widely—ranging from 12% to 55%, according to a report from the Office of Juvenile Justice and Delinquency Prevention (Snyder & Sickmund, 2006). This report notes that whether documented through rates of arrest, court referral, conviction, or correctional commitment and status changes, “virtually all measures of recidivism underestimate reoffending since they only include offending that comes to the attention of the system” (Snyder & Sickmund, 2006, p. 234).

Despite the problem’s scope, even one instance of a youth not reoffending means not only less burden on the system, but also the addition of that one individual’s positive energy and engagement in society. To increase such outcomes, a wide variety of efforts have emerged. Common approaches to reducing recidivism have included institution-based and therapy programs such as aggression replacement training, juvenile drug courts, inter-agency cooperation programs, restorative justice interventions, and a range of individual clinical interventions (Allard, Ogilvie, & Stewart, 2007). To complement these formal institutional and clinical efforts, an array of community-based services have also been developed—from intensive supervision, life skills development, and adolescent diversion projects to alternative schools, vocational rehabilitation programs, and halfway houses (Allard et al., 2007).

As funding options are being reduced, decisions about where to best invest time and resources grow increasingly crucial. This has naturally prompted heightened attention toward outcome research that identifies those interventions with the greatest success in reducing recidivism (Latessa & Lowenkamp, 2006). Generally speaking, community-based efforts to reduce recidivism have proven more successful than their institutional counterparts (Andrews et al., 1990; Dembo, Wareham, Poythress, Cook, & Schmeidler, 2000; Dembo, Wareham, Schmeidler, & Chirikos, 2005; Henggeler & Schoenwald, 2011; Lipsey, 1999).

Across institutional and community programs, however, one barrier to improved recidivism remains especially salient: Like an alcoholic returning to the same home atmosphere following successful treatment, youth who return to a similar family environment when released from treatment are clearly at increased risk of reoffending. Regardless of improvements resulting from treatment, if the home atmosphere remains unchanged, an unacceptably high percentage of youth will likely revert to their past negative behaviors.

From such awareness, conventional programming has sought to invoke family participation as much as possible—from institutional parent involvement and family-integrated transitions to multidimensional treatment foster care and a variety of family therapy programs (e.g., functional family therapy or multisystemic therapy). In a meta-analysis of 35 experimental studies of interventions for adjudicated youth, interventions that directly involved family members reduced recidivism at greater rates than more conventional youth-focused services (Latimer, 2001). While the addition of any family component to a program appears to improve outcomes and reduce recidivism (Timmons-Mitchell, Bender, Kishna, & Mitchell, 2006), one particular way of working with families is drawing increased attention.

Rather than removing youth or family from a home environment during service delivery, an in-home approach seeks to work and operate in the youth’s place of residence, on the family’s own “turf” (Hess, Barr, & Hunt, 2009). A recent Division of Child and Family Services audit in Utah concluded that in-home services not only result in better outcomes for children but were also more cost effective in that they often “prevent . . . expensive and disruptive foster care placements” (Office of the Legislative Auditor General, 2011).

The genre of in-home interventions is heterogeneous, differing most basically with regard to who conducts the service. The interventions studied most often involve professional

therapists entering the home (e.g., Timmons-Mitchell et al., 2006). Although there are obvious benefits to having trained clinicians offering needed services, such interventions are typically expensive. According to some psychological research, trained paraprofessionals can be effective agents of change, with outcomes often equivalent or comparable to those achieved by professionals (Boer, Wiersma, Russo, & Bosch, 2005; Bright, Baker, & Neimeyer, 1999; Durlak, 1979; Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010). In terms of in-home paraprofessional interventions, some impressive outcomes have been documented across diverse situations, including those targeting risk factors of low-income new mothers (Katz et al., 2011; Olds et al., 2004; Walkup et al., 2009); adults facing depression or anxiety (Boer et al., 2005; Montgomery et al., 2010); youth at risk for suicide (Gray, Dawson, Grey, & McMahon, 2011); and families struggling with aggressive children (Lewis, 2005). Nevertheless, the assumption that effective interventions must be delivered by professionals remains widespread.

More extensive research on this subject is therefore needed. In 2010, the Utah Juvenile Court commissioned the University of Utah's Criminal Justice Consortium to conduct a study of its funded recidivism reduction programs. This article summarizes and reports recidivism outcomes from that analysis, specifically of one paraprofessional-delivered in-home program that had a notable impact on helping youth avoid committing future crime.

## The Intervention

### Assessment

Families First is an intensive in-home intervention that has been developed and used over the last 20 years, helping families with a variety of emotional and behavioral problems. While it was developed within a specific agency in Utah, the intervention is based on the Teaching-Family Model that has been tested and applied across

the nation and internationally (Fixsen, Blase, Timbers, & Wolf, 2001; Lipsey & Wilson, 1998). The program is designed to teach parents and youth essential skills that can help stabilize family relationships and overall home life. Many participating families live at or below the poverty level, with associated employment struggles and difficulty meeting basic needs for housing, clothing, and food. Youth in these families often have a history of interactions with the juvenile justice system.

Families with youth in the juvenile justice system are referred to Families First by the juvenile courts. But before the juvenile courts refer such youth to Families First, they evaluate each offender's and family's risk level and treatment needs using the evidence-based Protective Risk Assessment tool (Dewitt & Lizon, 2008). Information gathered about youth and family risk factors focuses the ensuing intervention in several ways. First, this information ensures that services target juvenile offenders who are at moderate to high risk for recidivism. Second, those delivering the intervention use risk information to target the development of a juvenile's social skills to meet his or her specific criminogenic needs—those that initiated this youth's involvement with the juvenile court system in the first place. This kind of focus on skills-based training has been shown to reduce recidivism compared with general community probation efforts (Lancaster, Balkin, Garcia, & Valarezo, 2011).

Along with specific risk profiles, information on the treatment readiness and personal responsiveness of offenders guides the intervention plan (Bonta & Andrews, 2010), which begins with the Jesness Inventory–Revised, a self-report measure that helps to differentiate between social maladjustment and emotional disturbance (Jesness & Wedge, 1984). The Client Evaluation of Self and Treatment is also used to confirm a youth's overall emotional adjustment, social functioning, and motivation at intake into Families First (Garner, Knight, Flynn, Morey, & Simpson, 2007).

## Training of Paraprofessionals

Following initial information gathering, a trained Families First paraprofessional “family specialist” goes into the home of a referred family for an average of 8 to 10 weeks, spending between 6 and 10 hours a week with the family over multiple visits during the week. To be hired as a Families First specialist, an applicant needs a bachelor’s degree and previous experience working with youth. Family specialists are then trained in a comprehensive parenting and family skills protocol based on two models specifically linked to decreased recidivism: the Risk, Need, and Responsivity Model (Bonta & Andrews, 2010), and the Teaching-Family Model (Fixsen et al., 2001). A meta-analysis of more than 200 studies examining programs with a documented reduction of reoffense rates found “consistent evidence” for positive effects associated with the Teaching-Family approach (Lipsey & Wilson, 1998, p. 86).

Training of Families First specialists takes place in three stages. The first involves training on policies, procedures, and teaching models in a classroom setting over a 2-week period; during this time, trainees also conduct a few “shadow” visits with other specialists. In the second stage, new specialists accompany and observe a supervisor during an entire 8-week intervention. In the third stage, about halfway through this apprentice intervention, specialists receive their first family assignment, with the supervisor accompanying them on at least half of these visits. In addition to in-home observation, new specialists participate in weekly supervision and staff meetings. Over the course of this first year, the amount of direct supervision tapers; new specialists must pass a formal evaluation after 1 year. This rigorous training process ensures high treatment fidelity within the program.

## Implementation

Throughout a typical in-home intervention, a Families First specialist is on call and available to the family 24 hours a day, 7 days a week. From

crisis intervention and support to on-demand teaching and coaching for parents and youth, these specialists spend, on average, 6 to 10 hours with a family weekly—reflecting one unique benefit of paraprofessional-based services. In addition to individualized teaching and real-time skills development, these paraprofessionals also spend time in relationship-building activities and service to the family. A primary focus of these efforts is addressing the parent/child conflicts and general deficiencies in social skills that first brought the youth into the court’s purview.

Based on Protective and Risk Assessment results and the expressed desires of the families, Families First specialists target a juvenile’s specific social skills to meet the goals of the parent(s) as well as the youth’s criminogenic needs. Typically, Families First specialists target six general domains of need: school, use of free time, relationships, current living environment, skills, and attitudes and behaviors (Dewitt & Lizon, 2008). The visits of the Families First specialists allow time for the skills in each of these domains to be both practiced and tested in actual living situations. Along with skills specific to their own situations, Families First specialists commonly teach youth how to resist peer pressure, develop consequential thinking skills, improve impulse control, and express feelings in pro-social ways. The specialists use positive reinforcement, modeling, role-playing, cued practice, and other methods to illustrate these skills and help families practice them together.

As the intervention unfolds, the delivery of teaching follows a systematic “phases” approach developed by Boys Town, beginning with the establishment of rapport and goal setting, followed by the teaching of several key skills for successful parent-child relations and opportunities to practice and demonstrate (Peterson, Shadoin, & Kohrt, 1996). During a typical visit during a teaching phase, the specialist will follow up on previous assignments and the parent and youth level of skill use, as well as on the overall well-being and stability of the family. Depending on their progress, the specialist might introduce a

new skill or help to refine the family's use of a skill that they had previously been taught.

By working on family dynamics within their natural environment, the ultimate aim of the Families First specialist is to alter the instinctive responses of parents and juveniles toward each other until their interactions reflect a healthy balance of accountability and warmth (Fixsen et al., 2001). Along with communication skills and bonding activities, the importance of positive reinforcement, effective consequences, continual supervision, and basic household structure are all emphasized as essential to reducing the risk of further recidivism. By cultivating new habitual responses and concretely tying those responses to the rewarding behavior of others, the intervention thus seeks to sculpt the home environment into a mutually rewarding parent/child dynamic.

After concluding the intensive in-home period, the Families First specialist continues to be on call 24 hours a day for the next year as a continuing support to the family. The specialist also conducts four brief evaluations of the juvenile and family during the first year to track long-term success and help families overcome any obstacles that may arise: one at 30 days, one at 3 months, one at 6 months, and one 1 year after the completion of the intervention. These periodic check-ins focus on a family's overall stability, new problems, additional needs, and any skill review that may be indicated.

## Method

### Demographics

One hundred fifty-four juvenile court youth enrolled in the Families First program participated in the study. Most often, these youth were referred by the juvenile court system, with a subset coming directly to the program without a referral. In terms of age, most of the youth ranged from 15 to 17 (83%), with another smaller group ranging from 12 to 14 (16%) and a fraction of

participants who were 18 (1%). In their intake paperwork for the Families First intervention, participating parents gave their informed consent for questionnaires to be used in research.

In the Families First sample, 79% of adjudicated youth were male and 21% were female. About half of juvenile clients were Caucasian (48%), with Latino families accounting for the next largest group of clients (36%). African Americans (4%), Pacific Islanders (4%), American Indians (1.5%), and Asians (1.5%) accounted for the remaining 11% of the families.

In terms of criminal charges before intake, Families First clients reflected offense levels comparable to those of the average youth-adjudicated population (a mean of 5 misdemeanors, 1 felony, 1 status offense, and 0.5 technical charges). Across the study, risk scores confirmed various levels of youth risk, from low risk (25% of youth) to moderate risk (39%) to high risk (36%), with approximately 75% of participating youth determined to be at moderate or high risk for further criminal recidivism.

### Measures

We used the Protective and Risk Assessment, based on Washington State's Prescreen Risk Assessment, a validated measure used in Utah to evaluate youth risk and protective factors to help juvenile probation officers develop service recommendations (Dewitt & Lizon, 2008). Along with this measure, we used a comprehensive database of juvenile offenses committed within the state to compute the number of offenses, by age, for each youth.

We also used several measures from the Communities that Care Survey (Arthur et al., 2007) to evaluate the intervention before and after implementation. This survey is a needs-assessment tool exploring a variety of risk and protective factors designed to help communities plan and implement successful prevention programs (Arthur et al., 2007).

## Analysis

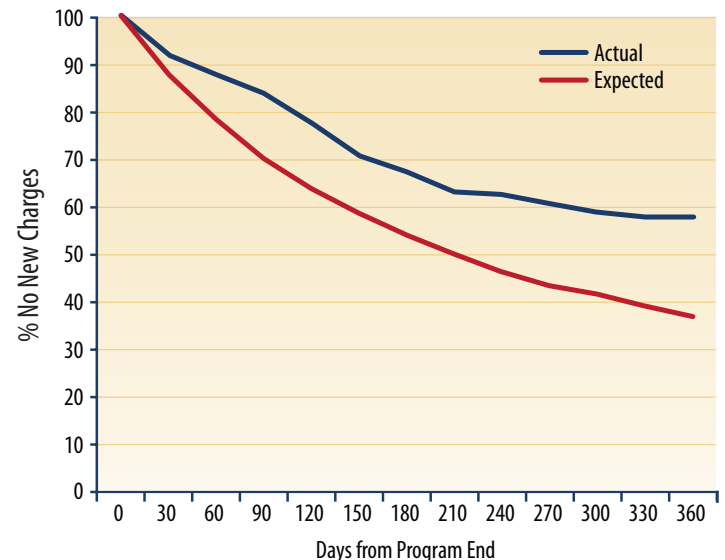
We used two methods to analyze the efficacy of the Families First intervention for court-referred youth. The first was a Kaplan–Meyer survival analysis, a method for comparing the times elapsed until a new criminal charge for different groups. This method is especially helpful for understanding reoffense rates over an entire year rather than just at individual points in time. This analysis used a risk-adjusted comparison group to compare times to new misdemeanor or felony charges 1 year from program completion. The treatment group for this analysis consisted of 154 youth who had either completed Families First or dropped out (the court data system does not distinguish between these two groups). The comparison group consisted of 3,064 youth who had received similar sanctions from the juvenile court, but with no in-home support. The interval of measurement for the survival analysis was one time point per month for 1 full year.

Since individual programs in the juvenile court differ on risk levels for participating youth, we made an important adjustment for this study. After we placed the name of each youth into a matrix that combined the Protective and Risk Assessment score with the youth’s juvenile court history, we created a 1-year survival curve for each matrix cell (that is, the expected 1-year recidivism survival curve of youth with a high Protective and Risk Assessment score and a court criminal history of II [see Table 1 for an explanation]). Next, we placed only the name of the youth in the Families First program into the matrix (see Table 1). We used this matrix of program youth to weight each one of the general survival curves, which we then took to represent the expected recidivism of youth in the program. Ultimately, we plotted this program’s recidivism survival curve next to the generally expected recidivism survival curve, using a log-rank chi-square test to determine whether the youth in the program performed better or worse than expected (see Figure 1).

**Table 1. Matrix of Prescreen Risk Assessment (PSRA) Risk Score by Court Criminal History**

Court Crim. History	PSRA Score					
	Low		Moderate		High	
	N	%	N	%	N	%
I (Low)	19	11	27	15	14	8
II	16	9	24	13	22	12
III	2	1	7	4	13	7
IV	4	2	8	4	9	5
V (High)	0	0	3	1	4	1

**Figure 1. Kaplan–Meyer Survival Curve for New Charges 1 Year after End of Families First Program (Completers and Non-Completers)**



The second method of analysis was a within-subjects analysis of results from the Communities that Care Survey of participating youth before and after the intervention. This analysis used a matched subject *t*-test to examine attitude changes among youth, which we based on survey results administered to youth at the beginning and at the end of the Families First program (see Table 2). The results should be interpreted carefully, because we did not make an alpha-adjustment for the multiple tests due to an expected loss of power based on this sample size. Because one or two statistically significant results could

be expected by chance, only several indicators showing positive change should be interpreted as positive results.

**Table 2. Matched T-Tests for Youth Given Pre- and Post-Questionnaires for Communities That Care Youth Survey**

	Cohen's d	df	T
<b>Scale</b>			
Rebelliousness	-0.25	95	2.92**
Attitudes Favorable to Antisocial Behavior	-0.22	94	2.21*
Attitudes Favorable to Drug Use	-0.21	95	2.69**
Rewards for Antisocial Involvement	-0.14	92	1.31
Belief in Moral Order	0.24	95	2.96**

\* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ .

## Results

A Kaplan–Meyer survival analysis using the log-rank test indicated that the Families First group had a significantly lower recidivism rate than the risk-adjusted juvenile court group, based on a 1-year follow-up of new misdemeanor or felony charges;  $\chi^2(1) = 19.40$ ;  $p < 0.001$  (see Figure 1). The lines on the chart represent the percentage of youth who had no new charges at each follow-up time. As noted in the Methods section, we adjusted the comparison survival curve to match the risk and criminal history of youth in the Families First program.

Based on matched-pair *t*-tests of the Communities that Care scales, this analysis found that the program reduced self-reported rebelliousness ( $d = -0.25$ ), attitudes favorable to antisocial behavior ( $d = -0.22$ ), and attitudes favorable to drug use ( $d = 0.21$ ) and increased belief in the moral order ( $d = 0.24$ ). Rewards for antisocial involvement showed no change (see Table 2).

## Discussion

These results underscore a number of conclusions specific to in-home services and regarding recidivism outcomes generally. Most basically, in-home interventions that rely on paraprofessional

teachers can have a measurable impact on recidivism rates. In particular, these results confirmed significant reductions in rebellious and antisocial attitudes and an increased belief in the moral order following the in-home intervention. Since changes in these attitudes accompanied the changes in documented offenses, we conclude that the in-home training of the family played a meaningful role in ensuring reduced recidivism over time.

Although the change in attitudes and behavior documented are of the youth alone, both the short- and long-term differences observed are arguably connected to the family-wide intervention focus. That is, youth attitude and behavior change are likely deeper and more sustainable when parents are also shifting their own attitudes. As real change happens in the child's continuing daily environment, youth vulnerability to rearrest therefore declines significantly.

As with any study, this one has its limitations, including the fact that we did not measure attitude change of parents as part of the documented change. Also, although we adjusted the comparison group for level of risk, the comparison group was not matched to take into account other factors that may influence reoffense rate.

Taking into account these limitations, these findings are consistent with evidence from other in-home interventions, including significantly lower rates of new charges, significant reduction in rearrest with Multi-systemic Therapy (Timmons-Mitchell et al., 2006), and fewer new arrests with the Family Empowerment Intervention (Dembo, Ramirez-Garnica, et al., 2000). In addition to confirming the benefits of family and community-based care for recidivism reduction (Andrews et al., 1990; Dembo et al., 2005; Latimer, 2001; Lipsey, 1999), our results also contribute to the discussion of potential improvements in aftercare (Ziedenberg, 2006). Above all, this study adds to the growing literature on the outcomes of paraprofessional in-home interventions for a variety of problems (Dembo, Ramirez-Garnica, et al., 2000;

Gray et al., 2011; Lewis, 2005; Olds et al., 2004; Walkup et al., 2009). Within a professional context that predominantly emphasizes professional therapy, counseling, and medical treatment, these findings suggest that increasing attention be paid to the potential of paraprofessional help for families in their own homes. Because it is not immediately obvious to the larger treatment system why a paraprofessional-based in-home intervention would lead to considerable positive outcomes, we conclude this article by elaborating on key features that make this approach an attractive complement to the current system: the first two common to all in-home services, the second three especially relevant to those centered on paraprofessionals.

### Family-wide Change

By basing services in the home, this kind of intervention naturally aims to work with the larger family and home system. In this way, in-home work is predisposed to avoid the common presumption that the youth alone just “needs to be fixed.” Among other things, by spending considerable time in the home with the family, individual workers are able to see and reinforce the need for parental and systems change. This may underlie why family-focused, community-based interventions appear to have greater relative impact on recidivism than other types of interventions (Andrews et al., 1990; Latimer, 2001; Lipsey, 1999). The crucial impact of family factors may also explain why developmental early-intervention programs have the strongest evidence base in terms of reducing recidivism—with a 15% reduction, on average (Farrington & Welsh, 2003; Washington State Institute for Public Policy, 2001). Whether as prevention or direct intervention, in-home work appears to have substantial advantages.

These kinds of benefits are also displayed across conditions in more general treatment evaluations. The Families First intervention has been examined in two controlled experimental studies over the last 10 years, the first between 2001 and 2004

(Lewis, 2005), and the second between 2004 and 2007 (Gray et al., 2011). In the first study (Lewis, 2005), Families First was compared with a control group receiving professional services ordinarily available to schools and courts. This 3-year study documented statistically significant change in child behavior problems maintained 6 months later in Families First families, and demonstrated superior results relative to youth receiving typical services ( $t = 2.04, p = 0.043$ ) (Lewis, 2005). Statistically significant change by those participating in Families First was also found in access to concrete services and physical care and resources being maintained 6 months later (Lewis, 2005). In addition, Lewis found superior outcomes relative to usual services ( $t = 3.1, p = 0.002$ ) and in improved effectiveness of parent-child relationships ( $t = 2.33, p = .021$ ): “[Families] were able to describe important parenting techniques and practices taught in the . . . intervention some eight to 10 months earlier, which they were still using effectively at the time of the interview” (Lewis, 2005, p. 506).

The second of the two studies mentioned above (Gray et al., 2011) was conducted in collaboration with the University of Utah School of Medicine and focused on suicide risk among youth in the juvenile court system. In addition to decreases in suicidality, the combined in-home and psychiatric intervention yielded an apparent reduction in recidivism. Compared with a 43% rate of reoffending after 1 year among a control group receiving typical community services, those receiving Families First in conjunction with medication management showed a 23% rate of recidivism after 1 year ( $p = 0.22$ ). This was in addition to \$100,000 in total cost savings for treatment youth over the course of the study period (Gray et al., 2011).

### Generalizable, Enduring Change

More than simply being respectful of and empowering to the family, being on their home turf during an intervention arguably has an impact on the sustainability of learning and change. In



a traditional treatment setting, the lessons and insights gained from treatment happen in an external setting, foreign to the individual's own environment. By practicing these skills in a familiar context, the lessons are perhaps more likely to stick (Hess, Barr, & Hunt, 2009). Evidence from the first controlled study cited earlier confirms some sustainability in intervention effects over time:

**There was very little fall-off in the ... change from the initial post-test to the follow-up post-test (six months later), indicating a good level of maintenance of the overall gains that families reported in connection with the intervention... There was no area of response in which gains demonstrated at the initial post-test were lost... That families were maintaining these positive changes over a number of months is a hopeful finding ... [especially] in a field where many interventions have lacked staying power.** (Lewis, 2005, pp. 505–507)

We are currently organizing a long-term outcome study of the effectiveness of in-home paraprofessionals, using both qualitative and quantitative measures, focused on four specific cohorts of families: those facing depression, anxiety, attention deficit hyperactivity disorder (ADHD), and eating disorders. In addition to assessing the impact of using in-home paraprofessionals to assist and support families facing specific clinical conditions, we will be testing the long-term effects of different combinations of paraprofessional and professional medical and therapeutic interventions.

### **Intensity of Time**

The amount of time Families First specialists are available to spend in the home, in contrast with the amount of time available in usual out-of-home services or in-home therapy, is one likely factor in this study's positive results. On average, family specialists spend 6 to 10 hours with a family in any given week, in activities ranging from in-home teaching and skill-building to other activities and services. The extensive time invested by family specialists helps to build the specialist's credibility, trust, and relationship with the youth and the family that are all greater than

would otherwise be the case. In turn, the paraprofessional's teaching and skill-building become that much more effective.

### **Cost-Effectiveness**

Given the larger economic difficulties, it is important to point out that this level of time commitment and in-home work does not necessarily require more internal funds. In the health field, community in-home programs have been shown to cost significantly less than other options (Maurana & Rodney, 2000), an advantage resulting from both a reallocation of professional time and a greater reliance on community and student efforts.

The cost of this particular in-home program is \$4,156 per person, compared with the average residential treatment total cost of \$108,585 per person. Whether targeting youth or adult populations, the savings associated with such interventions can be substantial (Allard et al., 2007; Walfish & Gesten, 2008).

For 20 families assisted by Families First between 2000 and 2001, the actual cost of the intervention was compared with the projected cost of more standard social interventions typically used in crisis situations (i.e., 8 days of inpatient treatment followed by 25 days of outpatient day treatment). Compared with \$12,225 per family for standard treatment, in-home expenses ranged from \$4,240 to \$5,500, yielding an average savings of \$7,422 per family. Among all 20 families over the course of the evaluation, projected savings totaled \$148,435.

Given its relatively low cost, the Families First program is consistently offered at low or no cost to hundreds of families every year, through donations and external funding. Families who can afford it pay for it.

### **Scope of the Program**

A final logistical advantage of in-home programs, especially those employing paraprofessionals, is the sheer reach of the program in terms of how

many people can be served. The involvement of paraprofessional advocates also promises to significantly address the persistent staffing concerns already mentioned. As Cervenka and colleagues (1996) suggest:

**Although home-based structural and strategic family systems approaches have been tested when delivered by therapists, our view is that only when such interventions are delivered by staff who have received less than a masters' level training can interventions be applied on the scale that is needed to respond to the overwhelming problems of juvenile crime, drug use, family abuse, and related conditions. (p. 215)**

Compared with 340 youth helped in the Utah Youth Village residential treatment facility since 2002, during the same period the Families First intervention has served more than 2,400 families, including 643 in the last 2 years.

## Conclusion

In-home programs relying on paraprofessionals appear to have substantial and measurable effects on recidivism. On a broader level, the changes prompted by these interventions are unique in their adaptability to the home setting and seem to account for their sustainability. While such programs are accessible to a broader audience than are residential or traditional outpatient treatment programs, they are also more cost

effective. Given these benefits, paraprofessional in-home interventions deserve more attention and research. Of course, in some cases, institutional interventions and treatment are crucial and in-home interventions would be contraindicated. However, given the strength of outcomes, in-home interventions deserve consideration before families opt for institution-based interventions.

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