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Knowledge regarding adolescents with serious offending behaviors has expanded dramatically over the last couple of decades. This wealth of new information has contributed to our understanding of risk factors related to offending behaviors, as well as to our understanding of the trajectories of offending behaviors, the treatment of offending behaviors, and long-term outcomes for adolescents with offending behaviors. In addition, we also now know a great deal more than ever before about the developmental process, and in particular about adolescent brain development and its relationship to adolescent offending behaviors. All of this knowledge has created an exciting time in juvenile justice—a time in which treatment efforts for adolescent offenders can and should be well informed by research. The treatment program model introduced in this book, the Forward-Focused model (FFM), directly results from much of the knowledge that has been amassed to date on this group of adolescents. In fact, development of the model would not have been possible without the extensive practice, advocacy, research, and inquiry that have been conducted to date. The purpose of this text is to introduce the FFM and to identify and discuss the research and theory upon which the model is based.

Early Developments in the Field

The concept of juvenile justice was initially formalized almost two centuries ago with the creation of the first facility specifically for juvenile offenders. The House of Refuge in New York, which opened in 1824, constituted the first attempt in the United States

to separate adolescents from adults who had committed an offense (Fox, 1970). Other states soon followed suit, and 65 years later, in 1899, the first juvenile court was established in Cook County, Illinois. By 1925, juvenile courts had been established in all but two states (OJJDP, 2014). These developments may not have occurred, or may have taken much longer to be accomplished, had it not been for the work of the Society for the Prevention of Juvenile Delinquency, which was founded in 1825—the first major advocacy group devoted to the separation of adolescent offenders from adult offenders in both placement and treatment. Members of the society and others involved in similar efforts were motivated by the belief that adolescents are not simply little adults, and cannot be treated in the same manner as adults. As a result, juvenile courts conducted civil proceedings that were focused on adolescents as unique beings and rehabilitation efforts, as opposed to the criminal proceedings of adult courts, which were focused on the crime that had been committed.

The 1974 passage of the Juvenile Justice and Delinquency Prevention Act not only further promoted the differentiation between adolescent and adult offenders but also established the Office of Juvenile Justice and Delinquency Prevention (OJJDP)—now a division of the Department of Justice. The OJJDP would not have been possible had it not been for the pioneering work of the 1800s, and its inception has dramatically altered juvenile justice and is largely responsible for much of our current knowledge. This is because as a result of the OJJDP, juvenile justice became a national priority with a significant presence in the federal government and all the benefits associated with federal agencies—chief among them being part of the federal government's budget, one of the largest in the world. In addition to its inherent infrastructure of knowledge and policy development, the OJJDP is a key provider of funding for juvenile justice services at the national, state, and local levels. This office, along with other divisions of the Department of Justice, has been instrumental in significantly expanding service delivery and promoting knowledge of adolescents with offending behaviors.

However, while the OJJDP's role in the development of new knowledge cannot be overlooked, neither can the role of numerous professional associations, think tanks, and state and municipal governments. Indeed, countless groups and organizations have contributed both directly and indirectly to our new knowledge base. As a result, dedicated practitioners and researchers have been able to work collaboratively to consistently expand what is known and to delve deeper into learning all that remains unknown about this group of adolescents. Most significantly, practitioners and researchers alike have been able to unite around a topic of intense passion because of their shared commitment to increased understanding of adolescents with offending behaviors, and to learning how best to treat these behaviors.

What We Know Now

Echoing the Society for the Prevention of Juvenile Delinquency's declaration from almost two centuries ago that adolescents are not little adults, we now have significant evidence that adolescents are indeed clearly different from adults. Most compelling of all is what we now know about adolescent brain development; research in this area has arguably been one of the most significant scientific endeavors over the last decade. As a result of new discoveries, we have come to identify adolescents as behaviorally immature, as individuals who struggle with self-control, who have a difficult time understanding long-term consequences of behaviors, and who are vulnerable to the influence of others (Casey, Getz, & Galvan, 2008; Scott & Steinberg, 2008; Steinberg, 2009a). The period of adolescence is unique, and what takes place then must be viewed through a developmental lens. Behaviors and emotions exhibited during adolescence may be much more a reflection of this distinct period in life than a snapshot of the individual over time or a projection of what is to come.

In addition, we have begun to understand that the period of adolescence may extend well into one's twenties; the emergence of adulthood is a long-term process (Arnett, 2000). While it has long been theorized that developmental stages do not correspond to fixed chronological ages, we now have evidence that the lengthy process of brain development often is not finalized until well beyond the teens.

Concurrent with this expanding knowledge of adolescence and adolescent brain development has been the ever-growing body of knowledge about trauma and the role it plays in the developmental process, especially among children and adolescents. Moreover, new discoveries into trauma have emphasized the critical place that treatment of trauma must have in our work with affected children and adolescents. We now know that trauma and adolescent development may be significantly interrelated; assessment and treatment efforts must therefore be designed both to identify the role that trauma may have played in an adolescent's life and to provide treatment in a manner that addresses trauma and developmental issues in an integrative manner.

We also now know much more than ever before about the role that family plays in an adolescent's life. More important, we know the significant and positive role that a supportive family member or other adult can have on an adolescent, and the degree to which a supportive adult can influence an adolescent's long-term life outcomes. Family and/or supportive individuals must be involved in the treatment of an adolescent with offending behaviors—they may be instrumental to the adolescent both during and following treatment.

Significant gains in knowledge about each of these three areas—adolescent

development, trauma, and the role of a supportive adult—have dramatically increased our understanding of adolescent treatment. Moreover, these gains have offered the juvenile justice system critical new insights that can be applied to assessment, treatment design, and treatment delivery. The Forward-Focused model was developed in response to these tremendous strides, and as such, it is based on what we now know about adolescents with serious offending behaviors.

The Forward-Focused Model

The Forward-Focused model for treating adolescents with serious offending behaviors is an empirically guided model that integrates current research and knowledge throughout, from the theoretical and philosophical foundations upon which the model rests to the type and scope of interventions specifically designed to address adolescent development and growth. Further, the FFM reflects our most significant new knowledge about adolescents with serious offending behaviors, including an emphasis on the role of trauma and risk factors, the promotion of identity development and social support, the use of experiential learning, and the development of effective coping skills. It is based upon the recognition that adolescents require treatment that is dramatically different from adult treatment in both content and delivery. Most important, it is based on the premise that court-involved adolescents face tremendous risks concerning their long-term success in life that may be directly related to their involvement in the juvenile justice system. As a result, the FFM emphasizes pro-social development, promotes healthy developmental transitions, and centers on independence and long-term life outcomes.

Why the FFM Is Unique

The Forward-Focused model addresses a significant gap in the current treatment of adolescents with serious behavior problems, not because it necessarily introduces new concepts in juvenile justice treatment, but rather because it draws from the sum of knowledge that we have amassed and incorporates all of it into the treatment model. Other models currently exist that emphasize one, two, or three of the components of the FFM, such as family-focused interventions, trauma-informed treatment, or movie therapy. Further, the majority of treatment programs today include reentry planning and individualized treatment planning as primary components, since both are best practices in juvenile justice.

The FFM, however, includes not only family-focused interventions, trauma-informed treatment, movie therapy, and a team-based approach, but also plant care, pet care, bibliotherapy, and substance use assessment and treatment. Moreover, the FFM specifically addresses adolescent brain development through both assessment and the design of clinical interventions. In addition to the distinct nature of its design, the model is unique in how it is packaged. While some other treatment models include either a workbook or a text, the FFM's complete treatment package comprises a detailed text, a user's manual (*FFM Facilitator's Manual*), and a workbook (*FFM Youth Workbook).*

Current Implementation of the FFM

While the FFM is empirically designed—rooted in an evidence-based theoretical framework and made up of evidence-based treatment components—a rigorous long-term outcomes evaluation of the FFM has not yet been completed. This is not unexpected considering the recent time frame in which the model was developed, and given that the vast majority of treatment programs used today in juvenile justice settings have not been rigorously evaluated, either.

The FFM is currently being implemented in juvenile justice facilities in two states (California and Michigan) with highly positive initial results related to both process and outcomes. Further, initial reactions of juvenile justice professionals, national experts, and participating adolescents and families have been most favorable. While the initial data are quite promising and speak to the model's potential success, a long-term outcomes evaluation is anticipated over the next several years and will be necessary to establishing the model's evidence basis.

Intended Settings

The FFM was designed for implementation in residential treatment settings. There are several reasons for this, including but not limited to the intensity of the model, the role of a treatment team in its delivery, and the model's primary use with adolescents with serious behavior problems, who are most likely to be placed in residential facilities. In addition, the three modalities that the FFM uses in treatment delivery—individual, group, and family interventions—are much more commonly used in residential settings. Still, the model can also be implemented in community-based programs, particularly if no barriers to treatment delivery exist (i.e., lack of group participants). This may in fact become increasingly common as more and more adolescents are diverted from residential treatment to community-based programming.

Clinical Facilitation

Because the FFM is a clinical treatment model, the clinically based treatment interventions (e.g., assessment, therapeutic modalities) should be implemented by a master's- or doctoral-level clinician. It is further recommended that a treatment team approach be employed when possible. This means that while the clinician is responsible for implementing the clinically based interventions, other treatment team members (e.g., case manager, direct care worker) will implement adjunctive and non-clinical components of the model (e.g., supporting and monitoring plant and pet care, facilitating family/support forums). Indeed, the significance of a treatment team is illustrated throughout the FFM and is central to the team-based philosophy of the model. However, because some treatment programs may not involve a treatment team approach, the individual clinician can in fact serve as the adolescent's treatment team.

The Purpose of This Text

As stated previously, the purpose of this text is to introduce the FFM and to illustrate the empirical knowledge upon which it is based. Moreover, the text provides readers with the evidence basis behind the various components and interventions contained within the model as well as the theoretical framework that binds the model together. Effective use of the FFM depends on practitioners and researchers fully understanding the intent and rationale of its design, and the text provides an essential introduction, particularly in regard to establishing its empirical background and fully explaining its rationale.

The text is not, however, intended as an instructional guide for implementing the model. The *FFM Facilitator's Manual* is available separately for this purpose. The manual contains detailed instructions for the facilitator(s) of each intervention; it provides additional background information for specific interventions as well. Excerpts from the manual have been included in this text.

In addition, the *FFM Youth Workbook* provides specific exercises for adolescents to complete independently; these exercises are related only to the stage work component of the FFM (one of the 11 primary treatment components). The workbook thus covers only a very small part of the FFM treatment program, whereas the facilitator's manual is used to guide the full implementation. This is because the FFM is an intensive clinical treatment program that requires close and ongoing facilitation by a clinician.

Used in concert, this text, the *FFM Facilitator's Manual,* and the *FFM Youth Workbook* offer a complete and comprehensive treatment program for adolescents with serious behavior problems. As such, the FFM constitutes an off-the-shelf treatment model that can be fully and effectively implemented within juvenile justice settings.

Terminology

The term *adolescents with serious offending behaviors* was chosen for use throughout this book so as to not pathologize or label these adolescents (i.e., juvenile offenders). *Serious* can denote many types of offending behaviors, including but not limited to substantial behaviors against property, violent behaviors against persons, and substance-related offenses. In addition, *serious offending behavior* is intended to include chronic offending behaviors. Use of the term *serious* is not intended to significantly limit the use of the FFM but rather to distinguish to some degree between adolescents who may have committed only a status offense and those who have demonstrated more severe offending behaviors. Ultimately, the juvenile justice professionals and legal representatives responsible for sentencing, assessment, and treatment decisions will determine which adolescents will participate in FFM-based programs.