BRIEF STRATEGIC FAMILY THERAPY IN MARYLAND: FY 2013 IMPLEMENTATION REPORT

Prepared by The Institute for Innovation & Implementation University of Maryland School of Social Work for the Children's Cabinet

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Executive Summary

Brief Strategic Family Therapy (BSFT) is one of five prioritized evidence-based practices selected by Maryland's Children's Cabinet with the goal of providing empirically-supported community-based practices that address key outcomes for youth and families (e.g., delinquency, family functioning, etc.). Since FY2011, the Institute for Innovation & Implementation has helped to support the facilitation of BSFT implementation in Maryland and continues to provide technical assistance and data reporting to providers.

FY13 Data Highlights

Utilization

- In FY13, BSFT was available in three jurisdictions throughout Maryland—Baltimore, Carroll, and Prince George's Counties.
- A total of 113 youth were admitted to BSFT in FY13. Nearly two-thirds of referrals were made internally by the BSFT provider organizations (36%) and parents/families (28%).
- The average age of youth admitted to BSFT was 13.0 years old, and the majority of admitted youth were Caucasian/White (59%) and male (64%).
- The majority of admitted youth had no previous involvement with the Department of Social Services (71%) or Department of Juvenile Services (83%).
- On average, youth and families started treatment within three weeks of referral during FY13.

Fidelity

- The percentage of youth served by certified therapists increased from 41% in FY12 to 90% in FY13.

Outcomes

- On average, youth attended 12.6 BSFT sessions over 149 days in FY13, compared to 10.6 sessions over 111 days in FY12.
- 111 youth were discharged from BSFT within the therapist's control in FY13, and **85% completed treatment.** This represents and an improvement from FY12, when 75% of discharged youth completed treatment.
- Of youth who completed BSFT in FY13, at the time of discharge:
  - **95%** were living at home;
  - **97%** were in school or working*; and
  - **97%** had no new arrests.
- Of the youth who completed BSFT in FY12, as of one year post-discharge:
  - **93%** did not have a new arrest;
  - **100%** had not been convicted;
  - **100%** had not been incarcerated;
  - **100%** had not been placed in a new residential placement with DJS; and
  - **Only 3%** had any new involvement with the child welfare system.

**Note: Based on data supplied by two providers; this information was not collected from the third provider until July 2013.*

Introduction

Purpose of this Report

Brief Strategic Family Therapy (BSFT) is a family-focused evidence-based practice (EBP), designed to help youth with drug use and behavior problems. In 2008, Maryland's Children's Cabinet committed to utilizing evidence-based and promising practices to ensure that effective community education, opportunities, support, and treatment options are available to the children, youth and families for whom they are appropriate. BSFT, which was already offered in a few jurisdictions in Maryland, was included as a prioritized EBP.

The Institute for Innovation & Implementation (The Institute) collects and analyzes data for a variety of EBPs implemented throughout Maryland. This report provides state and local stakeholders with a summary of BSFT implementation across the State for Fiscal Year (FY) 2013. In addition to utilization and fidelity indicators, both short- and long-term outcomes for participating youth are examined.

What is an EBP?

An **evidence-based practice (EBP)** is the integration of the best available research with clinical expertise in the context of youth and family characteristics, culture, and preferences. The effectiveness of an EBP to help children and families reach desirable outcomes is measured by three vital components (American Psychological Association [APA], 2002; APA Presidential Task Force on Evidence-Based Practice, 2006; U.S. Department of Health & Human Services, 1999):

1) Extent of scientific support of the intervention's effects, particularly from at least two rigorously designed studies;
2) Clinical opinion, observation, and consensus among recognized experts (for the target population); and
3) Degree of fit with the needs, context, culture, and values of families, communities, and neighborhoods.

What is Brief Strategic Family Therapy?

BSFT is a short-term, family-based treatment program for youth ages 6 through 17 who are displaying or at risk for developing behavior problems, including early substance use, conduct problems, truancy, association with problem peers, and delinquency. The primary goals of BSFT are to 1) prevent, reduce, and/or treat youth problem behavior, and 2) to improve family functioning.

The therapeutic model consists of three main intervention components: 1) joining, where the therapist establishes a working relationship with each family member and the family as a whole; 2) diagnosing familial behavior that may encourage problematic youth behavior; and 3) restructuring family interactions to become more effective in handling maladaptive behavior problems. Key approaches included in treatment are (1) focus on improving parent–child interactions; (2) parent training; (3) developing conflict resolution, parenting, and communication skills; and (4) family therapy. Therapy is typically delivered over 12 to 16 weekly sessions, though it may last longer based on the severity of the youth's problem behaviors. Treatment may be conducted in a clinic/agency office as well as home or community settings (Robbins & Szapocznik, 2000).

Experimental research has demonstrated positive outcomes for youth and families who participate in BSFT, including better family functioning, reduction in substance use, reduction in conduct problems, and reduction in socialized aggression (e.g., Coatsworth et al., 2001; Robbins et al., 2011; Santisteban et al., 2003). BSFT was originally developed to serve Cuban families (Szapocznik et al., 2012), but the model has also been effective for treating a wide variety of racial and ethnicity populations such as African Americans, Hispanic Americans, and White Americans (Robbins et al., 2011). Table 1 summarizes BSFT's

ratings on four nationally-recognized EBP registries. For additional information on BSFT, please go to www.bsft.org and www.fttim.com.

Table 1. BSFT Ratings on National EBP Registries*

EBP Registry	Website (for additional information)	BSFT Rating(s)
Blueprints for Healthy Youth Development	www.blueprintsprograms.com	Not Listed
California Evidence-Based Clearinghouse for Child Welfare	www.cebc4cw.org	2: Supported by Research Evidence (reviewed June 2012)
SAMHSA's National Registry of Evidence-Based Programs & Practices (NREPP)	www.nrepp.samhsa.gov	*Quality of Research** (reviewed April 2008):* Engagement in therapy=3.4 Conduct problems=3.4 Socializing aggression=3.4 Substance use=3.0 Family functioning=3.2 *Readiness for Dissemination** (reviewed April 2008):* Implementation Materials=3.3 Training & Support Resources=3.0 Quality Assurance Procedures=3.5 Overall Rating=3.3
Office of Justice Programs' CrimeSolutions.gov	www.crimesolutions.gov	Promising Program

**Ratings as of June 2014.* ***The scale range from 0 to 4.*

BSFT Implementation Support

Two BSFT purveyors work with the programs currently operating in Maryland—the University of Miami's Brief Strategic Family Therapy Institute serves the program delivered by Catholic Charities (Baltimore County), and the Family Therapy Training Institute of Miami (FTTIM) works with the Carroll County Youth Services Bureau (CCYSB) and the District Heights Family & Youth Services Center (DHFYSC). Both purveyors provide a structured training and certification approach to ensure that the evidence-based model is delivered with fidelity. This includes training workshops, therapist certification, training on-site supervisors, continuing supervision from a BSFT trainer, and/or site licensing. CCYSB currently employs a BSFT Trainer, who is certified by FTTIM. In addition to monitoring BSFT utilization, fidelity, and outcomes, The Institute facilitates Maryland provider and stakeholder collaborative meetings to ensure the most effective implementation of the model.

Assessing BSFT Utilization and Outcomes

The data presented in this report were drawn from youth-level data routinely submitted by Maryland BSFT providers.[1] Additional data were provided by the Department of Juvenile Services (DJS), the Department of Public Safety and Correctional Services (DPSCS), and the Department of Human Resources (DHR). Taken together, these data fall into three main categories—utilization, fidelity, and outcomes.

- ***Utilization data*** include demographic information, delinquency history, child welfare system history, and details of the case processing (e.g., referral sources, waitlist information, etc.). As a whole, utilization data indicate the "who, when, and why" for youth served by BSFT.
- ***Fidelity data*** measure the degree to which BSFT has been delivered as intended by the program developers.

[1] BSFT providers began collecting these data in January 2011.

- ***Outcomes data*** allow us to assess whether BSFT has achieved the desired results for youth and families (Table 2). The outcomes of particular interest in BSFT include engagement and treatment completion, reducing or eliminating youth substance use, decreasing delinquent behaviors and conduct problems, and improving family functioning. Whereas data regarding substance use and family functioning were not available for this report, other outcomes were measured using information collected by providers at treatment discharge and administrative data collected by state child-serving agencies.

Table 2. BSFT Outcome Data—Types and Sources

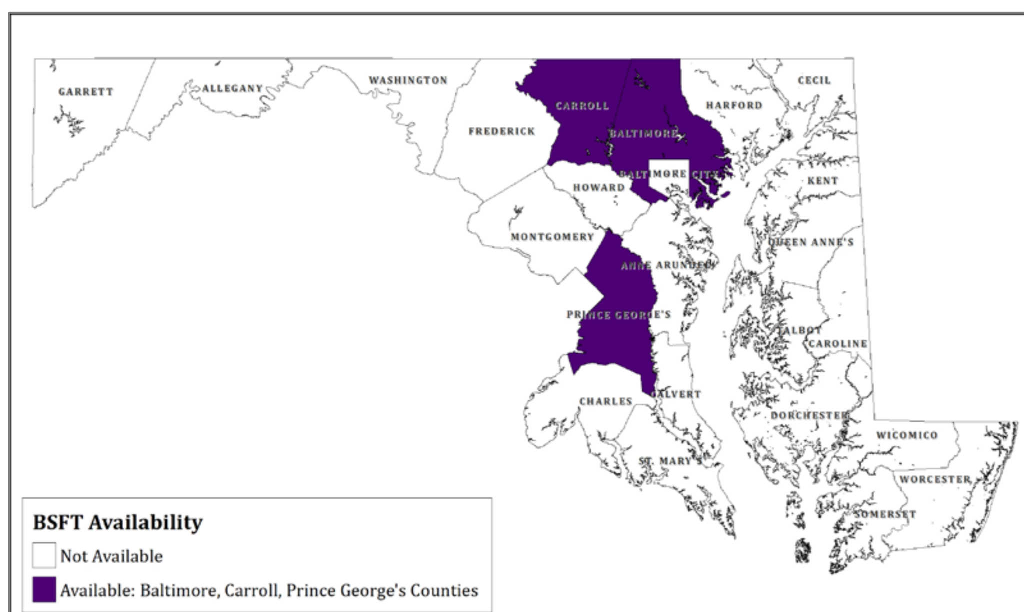
Type	Indicator	Source
Case Progress	➢ Treatment completion ➢ Reason for non-completion (if applicable)	BSFT Providers
Ultimate Outcomes at Discharge	➢ Whether the youth was living at home ➢ Whether the youth was in school or working ➢ Whether the youth had any new arrests	BSFT Providers
Longitudinal Outcomes	➢ Involvement in the juvenile and/or criminal justice systems (e.g., DJS referral/arrest, adjudication/ conviction, and commitment/incarceration) ➢ Involvement in the child welfare system (e.g., services and placements)	DJS DPSCS DHR

Descriptive and bivariate analyses (e.g., chi-square, t-test) are utilized to assess statewide utilization, fidelity, and outcomes data from FY13. Where possible, data are presented and comparisons are drawn for previous fiscal years. Please refer to Appendix 1 for FY13 descriptive data presented by provider and jurisdiction.

Where was BSFT Offered in Maryland?

In FY13, BSFT was offered in three counties in Maryland—Baltimore, Carroll, and Prince George's (Figure 1). BSFT was administered by three providers—Catholic Charities (Baltimore County), CCYSB (Carroll County), and DHFYSC (Prince George's).

Figure 1. BSFT Availability in Maryland, FY13



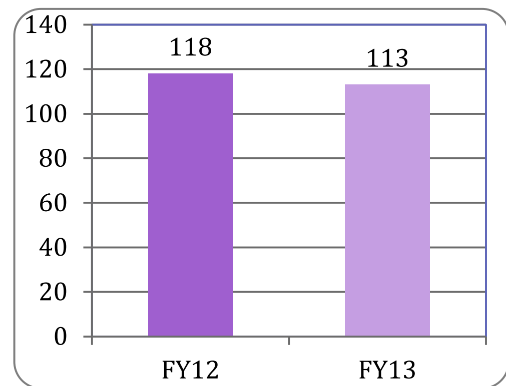
Admissions to BSFT

Maryland youth may be referred to BSFT from a variety of sources, which vary to some extent by provider and jurisdiction. In many cases, families seeking help will contact the provider directly and a Clinical Director or Referral Coordinator will suggest BSFT. Or families may request BSFT after finding information on the provider's website or via a flyer. A provider may also work closely with their local schools and DSS and DJS offices to advertise BSFT—families may be directly referred by one of these agencies, or the agency staff may suggest that the family contact the provider on their own.

The providers screen families to determine if BSFT is a good fit and whether they are amenable to the structure of the program. For instance, providers will ask what presenting problems have brought them to therapy, if they are willing to have all family members involved in treatment, as well as if they are willing to be videotaped (for fidelity monitoring purposes). BSFT is not appropriate for families in which a parent is engaging in significant substance abuse, or if a family member is actively psychotic. It is also not appropriate for a child that has an Autism Spectrum Disorder or other developmental disorder. Youth and families who are offered BSFT may elect not to start the program, and participation is voluntary.

In FY3, 113 youth were admitted to BSFT across Maryland, compared with 118 youth in FY12 (Figure 2).

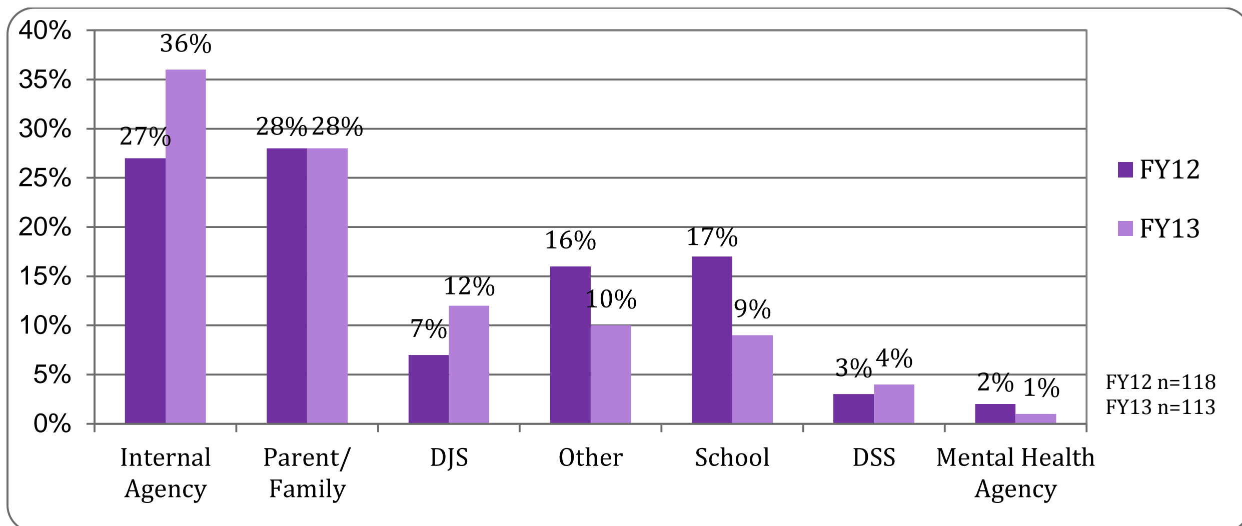
Figure 2. Number of Youth Admitted to BSFT, FY12-FY13



Referral Sources for Admitted Youth

In FY13, the majority of the 113 youth admitted to the program were referred internally by BSFT provider organizations (36%; also referred to as "internal agency"), followed by parents/family (28%), DJS (12%), and other sources (10%; Figure 3).[2]

Figure 3. BSFT Referral Sources, Percentage of Total Youth Admitted, FY12-FY13

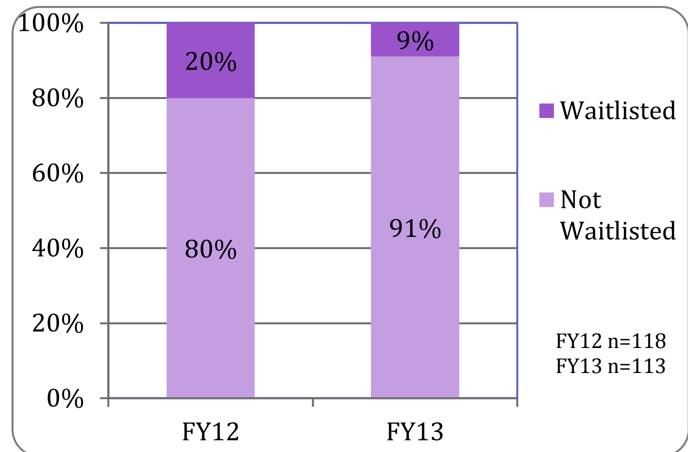


[2] BSFT providers do not submit data on all youth who are referred for treatment (i.e., including those who are not admitted) to The Institute.

Waitlisted Youth

In FY13, 9% (n=10) of admitted youth had been placed on the waitlist—down from 20% (n=24) in FY12 (Figure 4). Across both years, youth were placed on the waitlist almost exclusively because the program was operating at capacity; only one youth admitted in FY12 was placed on the waitlist for an "other" reason.

Figure 4. Percentage of Admitted Youth Placed on Waitlist, FY12-FY13

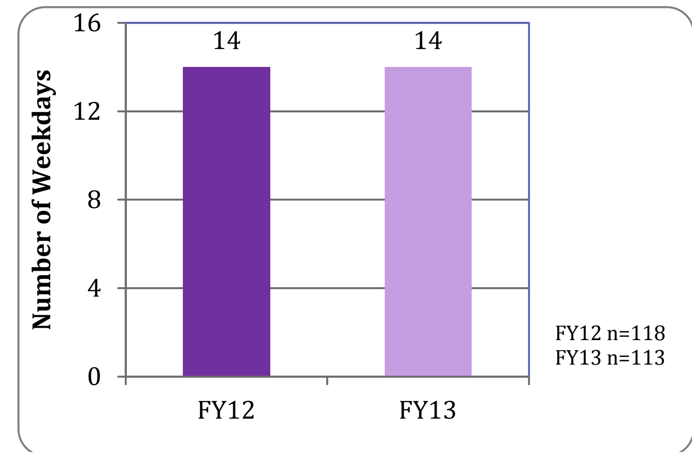


Global Admission Length (Initial Case Processing)

Once a youth is referred to BSFT, the providers work to ensure that the youth/family engages in treatment soon thereafter. BSFT providers report referral and start dates for youth admitted to the program so this process can be monitored. The number of days between the referral and start dates is referred to as the *global admission length*.

The average global admission length has remained constant over the past two fiscal years. In FY13, youth and families typically started treatment within 14 weekdays of referral (Figure 5). There were no statistically significant differences in the global admission lengths by subgroups of youth or by agency/jurisdiction, suggesting that all youth began treatment in similar timeframes.

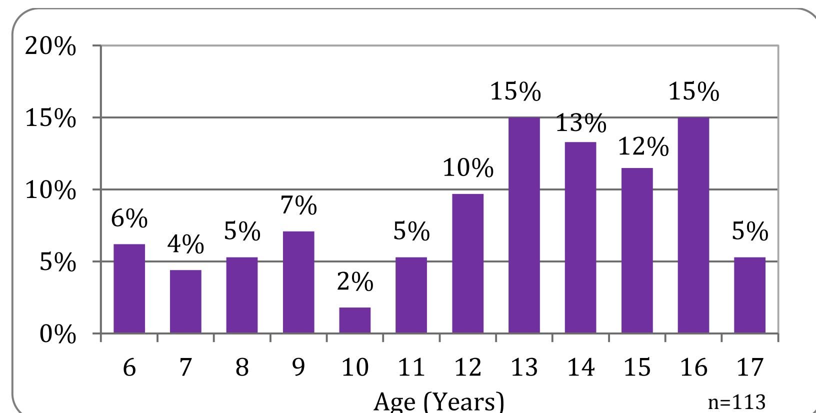
Figure 5. Global Admission Length for Admitted Youth, FY12-FY13



Characteristics of Admitted Youth

BSFT can serve male and female youth from diverse racial and ethnic backgrounds between the ages of 6 and 17 years old. Most youth admitted to BSFT in FY13 were between the ages of 12 and 16 years old (65%; Figure 6), and their average age was 13.0 years old. The majority of youth were male (64%) and Caucasian/White (59%; Table 3).

Figure 6. Ages of Youth Admitted to BSFT, FY13



The characteristics of youth admitted to BSFT have changed somewhat

over the past two fiscal years. A smaller proportion of African American/Black youth and a greater proportion of youth with Caucasian/White and other racial/ethnic backgrounds were admitted in FY13 relative to FY12. These changes are attributable, in part, to a decline in admissions by DHFYSC, which served primarily African-American/Black youth, in FY13 relative to FY12. Additionally, a larger proportion of males were admitted in FY13 (64%) than in the year prior (59%).

Table 3. Demographic Characteristics of Youth Admitted to BSFT, FY12-FY13

	FY12	FY13
Total Number of Youth	118	113
Male	69 (59%)	72 (64%)
Female	49 (41%)	41 (36%)
African American/Black	58 (49%)	37 (33%)
Caucasian/White	51 (43%)	67 (59%)
Hispanic/Latino	1 (1%)	0 (0%)
Other	8 (7%)	9 (8%)
Average Age (s.d.)	12.9 (4.4)	13.0 (3.2)

Involvement with DJS

In order to describe admitted youth's previous involvement with DJS, cases were matched with DJS's administrative data. Notably, several cases were missing information necessary for linking data across systems; only 86% of FY12 cases and 74% of FY13 cases could be matched to DJS data, and thus the following findings should be interpreted with caution. Of matched youth admitted to BSFT in FY13, 17% had at least one prior referral to DJS, which is consistent with those admitted in FY12 (13%; Table 4). Of those with previous DJS involvement, youth admitted in FY13 had, on average, three prior DJS referrals and their mean age at first referral was 13.5 years old. Only one youth had been previously committed to DJS.

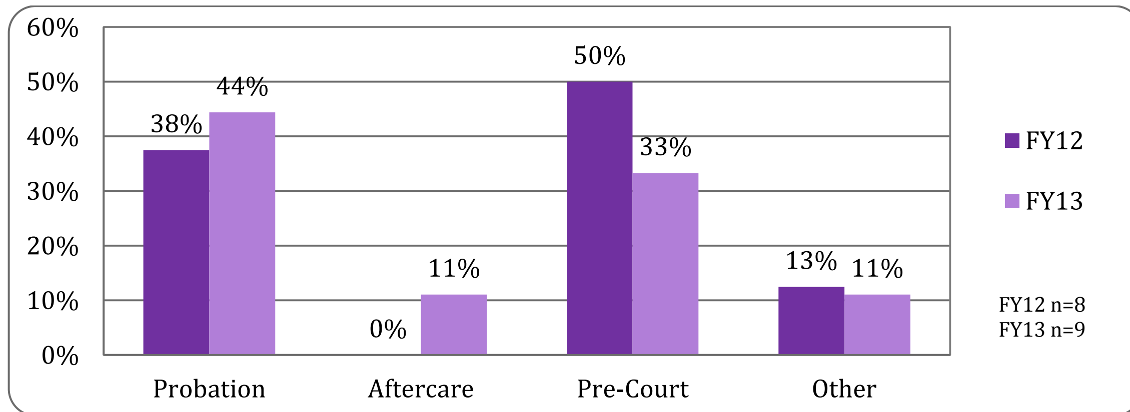
Table 4. Prior DJS Involvement for Youth Admitted to BSFT, FY12-FY13

	FY12	FY13
Total Number of Youth	118	113
Total Number of Matched Youth*	101 (86%)	84 (74%)
One or More Prior DJS Referrals	13 (13%)	14 (17%)
Avg. # of Prior DJS Referrals (s.d.)	1.1 (0.3)	2.7 (2.6)
Avg. Age at First DJS Referral (s.d.)	13.3 (2.4)	13.5 (2.1)
One or More Prior DJS Commitments	0 (0%)	1 (1%)
Avg. # of Prior DJS Commitments	0	1.0

*Several youth could not be matched to DJS data due to missing identifiers (17 cases in FY 12 and 29 cases in FY13); it is possible additional youth were involved with DJS.

The proportion of admitted youth who were actively involved with DJS increased slightly from 8% in FY12 to 11% in FY13. Of the nine DJS-involved youth admitted to BSFT in FY13, 44% were under probation, 11% aftercare (i.e., committed to DJS), and 33% pre-court supervision (Figure 7). Of the five youth under probation or aftercare supervision, one was involved with the Violence Prevention Initiative (VPI), a more intensive supervision program for youth who had previously been a perpetrator and/or victim of violence.

Figure 7. DJS Supervision for Youth Admitted to BSFT, FY12-FY13*

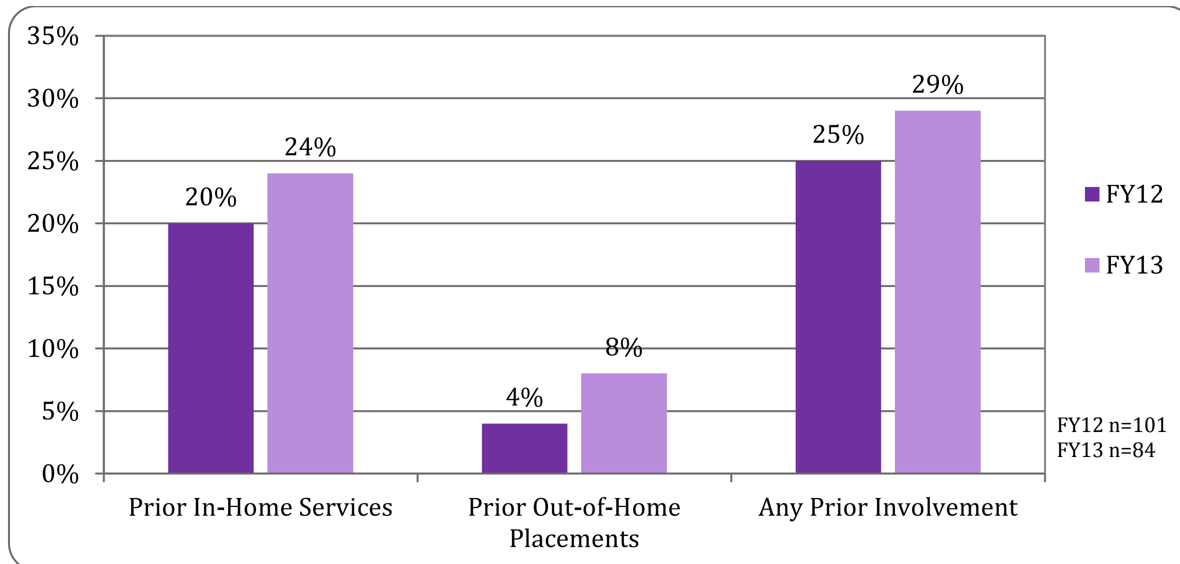


*Several youth could not be matched to DJS data due to missing identifiers (17 cases in FY 12 and 29 cases in FY13); it is possible additional youth were under DJS supervision.

Involvement with DSS

Youth admitted to BSFT were also matched with DHR's administrative data in order to describe their previous experiences with the child welfare system. Again, 14% of FY12 cases and 26% of FY13 cases could not be linked to child welfare system data due to missing identifiers, so caution should be exercised in interpreting findings. Of the 84 matched youth who were admitted to BSFT in FY13, 24 (29%) had some form of prior contact with Maryland's child welfare system (Figure 8), including in-home services and/or out-of-home placements prior to their BSFT referral. Twenty youth (24%) had received in-home services, and seven youth (8%) had been placed out-of-home. On average, youth were 4.9 years old at the time of their first in-home service and 4.8 years old at the time of their first out-of-home placement.

Figure 8. Prior DSS Involvement for Youth Admitted to BSFT, FY12-FY13



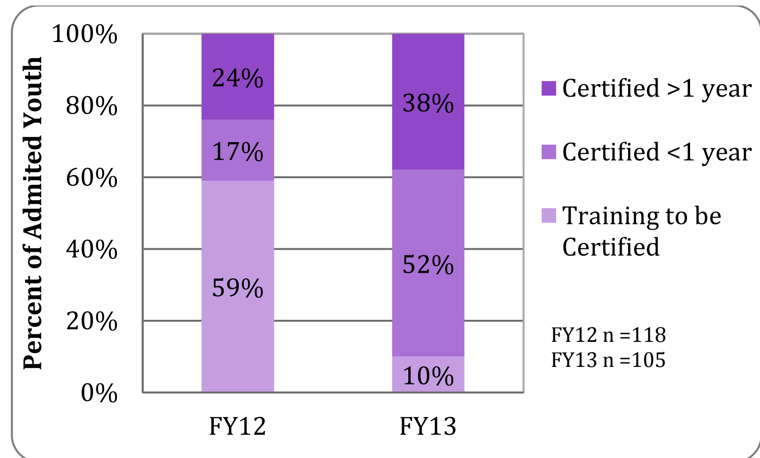
*Several youth could not be matched to DHR data due to missing identifiers (17 cases in FY 12 and 29 cases in FY13); it is possible additional youth had prior contact with the child welfare system.

BSFT Model Fidelity

If youth and families are to be helped, BSFT must be delivered in the way it was designed and with a high degree of clinical skill. Fidelity to the BSFT model is critical for successful implementation. As mentioned earlier, BSFT purveyors offer structured training, certification, and supervision approaches to ensure adherence to the treatment model. For instance, providers submit video footage of select sessions with families for review by the national purveyor, and supervision is conducted via telephone or video conference.

Standardized fidelity measures are not available for inclusion in this report; however, therapist certification status is tracked on an ongoing basis. Certification is measured as three categories: 1) training to be certified, 2) certified for less than one year, and 3) certified for more than one year. Figure 9 illustrates the BSFT therapist certification status for each youth admitted between FY12 and FY13. The percentage of youth served by certified therapists increased from 41% in FY12 to 90% in FY13.

Figure 9. BSFT Therapist Certification Status for Admitted Youth, FY12-FY13



BSFT Discharges & Outcomes

Of the 126 youth who were discharged from BSFT in FY13, 111 (88%) were discharged for reasons *within therapist control*. The remaining 12% of cases were discharged for reasons *outside of therapist control* (note that these cases will not be included in subsequent analyses).[3] The specific discharge reasons falling under each category are listed in Figure 10.

Figure 10. Discharge Reasons

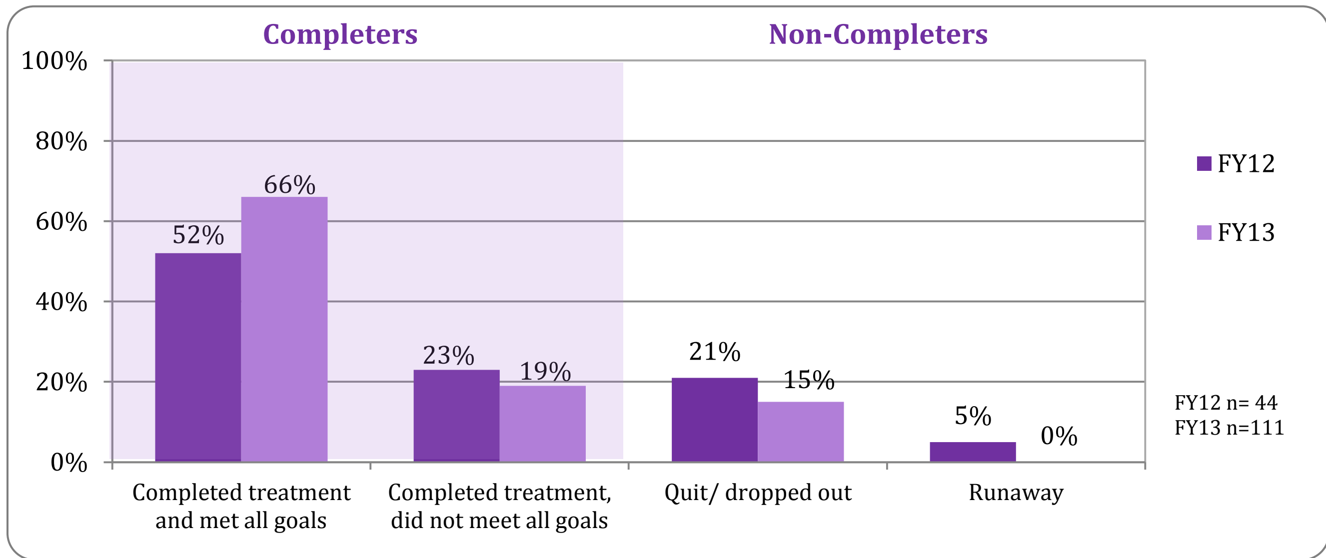
Within Therapist Control	Outside of Therapist Control
➢ Completed treatment and met all goals	➢ Youth/family moved
➢ Completed treatment without meeting all goals	➢ Youth referred to other services
➢ Quit/dropped out after contact	➢ Administrative reasons
➢ Youth ran away	➢ Youth was placed out-of-home (for an event prior to BSFT)
➢ Youth was placed out-of-home (for a new event during BSFT)	

As shown in Figure 11, the majority of youth completed BSFT (85%, n=94), an improvement over FY12 (75%, n=33); however, only 66% of youth completed treatment *and* met all treatment goals. Of those who did not complete treatment, the most common discharge reason was *quit or dropped out* (15% of all youth discharged within therapist control in FY13). Preliminary analyses reveal that African

[3] Of youth discharged for reasons *outside of therapist control*, six were discharged for administrative reasons, five were referred to other services, two moved away, and two were placed out of home for an event that occurred prior to starting BSFT.

American/Black youth were significantly less likely to complete BSFT (72%) compared with Caucasian/White youth (96%) and youth of other races/ethnicities (89%).

Figure 11. Discharge Reasons for Youth Discharged within Therapist Control from BSFT, FY12-FY13



Average Number of Sessions and Length of Stay

BSFT providers conduct treatment sessions both in the client's home and office settings, though the primary location varies by provider. Figures 12 and 13 show the average number of sessions and the average lengths of stay for youth discharged within therapist control in FY12 and FY13. Overall, youth who were discharged from BSFT in FY13 attended an average of 12.6 sessions over the course of 149 days in treatment. Those who completed the program attended a greater number of sessions (13.9) and were in treatment longer (159 days) than youth who did not complete BSFT, who attended an average of 5.2 sessions over the course of approximately 97 days. The average number of sessions for both completers and all youth discharged within therapist control were within the national purveyors' target ranges (approximately 12-16 sessions).

Figure 12. Average Number of BSFT Sessions, Youth Discharged within Therapist Control, FY12-FY13

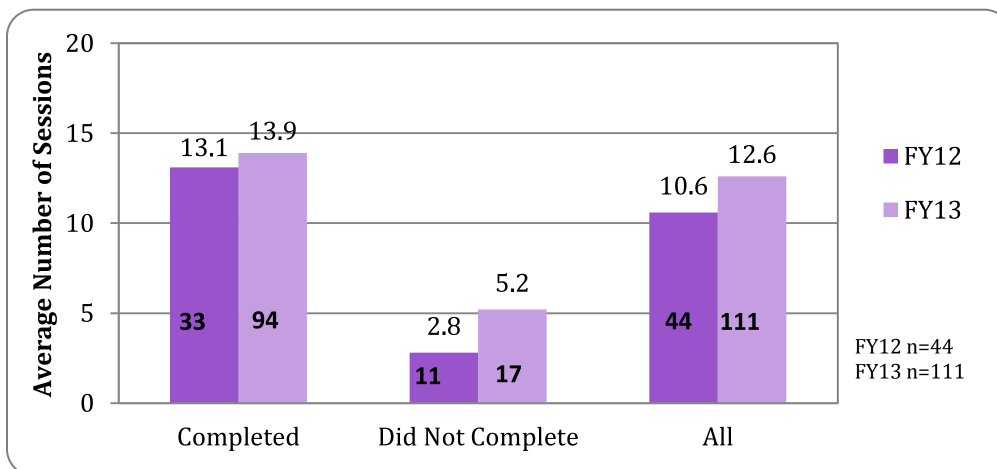
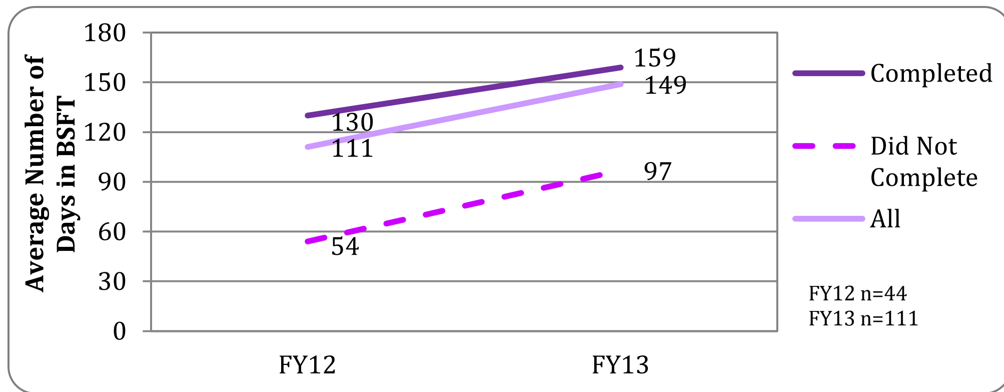


Figure 13. Average Length of Stay in BSFT, Youth Discharged within Therapist Control, FY12-FY13



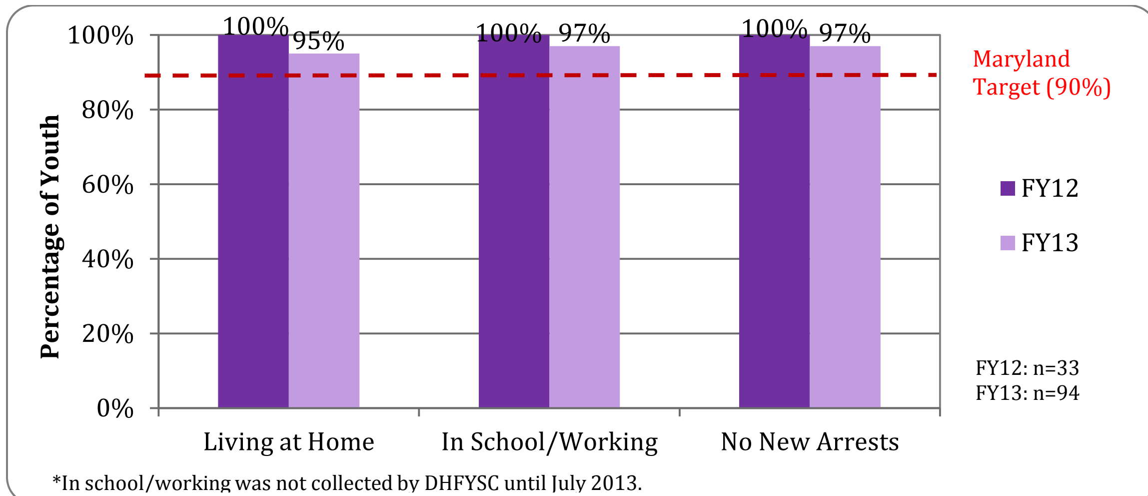
The length of stay in BSFT was significantly related to therapist certification, such that youth served by therapists who had been certified for longer than one year had longer lengths of stay (205 days), on average, compared to youth served by therapists training to be certified (142 days) and therapists certified for less than one year (123 days). While not statistically significant, females (163 days) spent more time in treatment, on average, than males (141 days). Substantial differences were also evident by agency/county (see Appendix 1).

Ultimate Outcomes at Discharge

Even though most youth completed BSFT, the program's level of effectiveness could vary across youth. Three measures of success reported by the providers at discharge constitute the *ultimate outcomes*: (1) whether the youth was living at home, (2) whether the youth was in school and/or working, and (3) whether the youth had been arrested for a new offense since treatment had started. Other indicators of success include post-discharge outcomes, which are discussed in the next section.

Figure 14 shows the ultimate outcomes for youth who completed BSFT (including both those who met all goals and those who did not) over the past two years. Maryland's target is 90% success for each ultimate outcome (i.e., 90% of youth who complete BSFT will attain each discharge outcome); this goal has been achieved in both FY12 and FY13.

Figure 14. Ultimate Outcomes at Discharge for Youth who Completed BSFT, FY12-FY13



DJS Involvement during Treatment

The ultimate outcomes are reported by BSFT therapists, who may not be aware of all youth contacts with law enforcement or the juvenile justice system. And not all contacts with the juvenile justice system may be the result of an arrest—youth may also be referred to DJS from other sources (e.g., school). According to DJS and DPSCS's data, 7% of youth had been referred to DJS/arrested while receiving BSFT in FY13 (of completers)—compared with the reported 3% who had new arrests upon discharge.[4] In addition, DJS data show that one youth (1%) was admitted to a DJS detention facility during treatment.

Juvenile & Criminal Justice System Involvement Measures

For the purposes of this report, subsequent involvement with the juvenile and criminal justice systems are combined and labeled as the following categories:

Arrested refers to any subsequent DJS referral or adult arrest.

Convicted refers to any juvenile complaint that is adjudicated delinquent at a judiciary hearing or any adult arrest that results in a guilty finding at a criminal court hearing.

Incarcerated refers to any commitment to DJS custody as a result of a complaint that is adjudicated delinquent, as well as incarceration in the adult system that results from an adult arrest and conviction.

Longitudinal Outcomes

Subsequent Involvement with the Juvenile and/or Criminal Justice System

In order to assess longitudinal outcomes in Maryland, The Institute provided DJS and DPSCS with the name, gender, race/ethnicity, and date of birth of all youth who were discharged from BSFT in FY12, and matches were identified in their respective databases. Following DJS' recidivism criteria, subsequent involvement with DJS and the adult criminal justice system were combined and categorized as arrested, convicted, and incarcerated (see the insert for definitions).

The majority of youth who completed BSFT in FY12 avoided contact with the juvenile and/or criminal justice systems within one year of discharge (Table 5). Of the 29 matched youth followed from FY12[5], two youth (7%) were arrested or referred to DJS. No youth who completed BSFT in FY12 were convicted, incarcerated, or placed in a DJS residential facility within one year of discharge.

Table 5. Juvenile and/or Criminal Justice System Involvement within 12 Months Post-Discharge, Youth who Completed BSFT, FY12

	FY12
Total Number of Youth	33
Total Number of Matched Youth*	29
DJS/CJS Involvement:	2 (7%)
Arrested	2 (7%)
Convicted	0 (0%)
Incarcerated	0 (0%)
Residential Placement with DJS	0 (0%)

*Four youth could not be matched to DJS/DPSCS data due to missing identifiers.

[4] Twelve youth (13%) who completed BSFT in FY13 could not be matched to DJS/DPSCS data due to missing identifiers.
[5] Four cases could not be matched to DJS/DPSCS data due to missing identifiers.

Subsequent Involvement with the Child Welfare System

The Institute also provided DHR with the names, dates of birth, and other demographic variables of all youth who were discharged prior to the last day of FY12. DHR matched these youth in their state SACWIS (State Automated Child Welfare Information System) system known as CHESSIE (Children's Electronic Social Services Information Exchange) to retrieve information about contact with the child welfare system post-BSFT discharge. As per DHR data, of the 29 matched youth who completed BSFT in FY12, only one youth (3%) had some form of new DSS contact, a new investigation, within 12 months of discharge. No youth were placed out-of-home in the year following discharge (Table 6).

Table 6. DSS Involvement within 12 Months Post-Discharge, Youth who Completed BSFT, FY12

	FY12
Total Number of Youth	33
Total Number of Matched Youth*	29
DSS Investigation	1 (3%)
In-Home Service	0 (0%)
Out-of-Home Placement	0 (0%)

*Four youth could not be matched to DHR data due to missing identifiers.

FY13 BSFT Implementation in Maryland: Successes & Challenges

Utilization

- BSFT was offered in three counties—Baltimore, Carroll, and Prince George's.
- The number of BSFT admissions dropped slightly from 118 in FY12 to 113 in FY13.
- The majority of youth were referred to BSFT by the provider or by the parent/family—just 12% were referred by DJS, 9% by schools, and 4% by DSS.
- The global admission length remained the same from FY12 and, on average, youth and families started treatment within three weeks of referral during FY13. There were no significant differences in global admission length by subgroups of youth or by agency or jurisdiction.
- More than half of the youth admitted to BSFT in FY12 and FY13 were male (59% and 64%, respectively). The average age of youth participating in BSFT was 13 years old.
- The majority of youth admitted to BSFT had no previous involvement with DSS (71%) or DJS (83%). Future analyses will include additional system and risk/need indicators to better assess the characteristics of youth served.

Fidelity

- The percentage of youth served by certified BSFT therapists increased from 41% in FY12 to 90% in FY13.

Outcomes

- Approximately 85% of discharged youth completed treatment in FY13, which represents a notable improvement compared to the discharge cohort from the previous fiscal year (75%). However, significantly fewer African-American/Black youth completed treatment relative to Caucasian/White youth or youth of another race/ethnicity; reasons for these results should be explored.
- Both the average number of sessions and the average length of stay in BSFT increased from FY12 to FY13. On average, youth attended 10.6 BSFT sessions over 111 days in FY12, compared to 12.6 sessions over 149 days in FY13. In FY13, youth whose therapists were certified in the model for at least one year spent significantly longer durations in treatment.
- For the second consecutive year, youth who completed BSFT have exceeded Maryland's target of 90% on each of the ultimate outcomes (i.e., living at home, in school/working, and no new arrests at discharge).
- Of youth who completed BSFT in FY12, approximately 93% has no new arrests, and none of the youth were convicted or incarcerated, in the year following treatment completion.
- None of the youth who completed BSFT in FY12 were subsequently admitted to a DJS residential facility in the year following treatment completion.
- Only one youth who completed BSFT in FY12 (3%) had new involvement with DSS in the year following discharge.

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