FUNCTIONAL FAMILY THERAPY IN MARYLAND: FY 2013 IMPLEMENTATION REPORT

Prepared by The Institute for Innovation & Implementation
University of Maryland School of Social Work

JUNE 2014

Suggested citation: Farrell, J., Betsinger, S., Chen, D., Mettrick, J., Dutrow, D., & Zabel, M. (2014). Functional Family Therapy in Maryland: FY2013 Implementation Report. Baltimore, MD: The Institute for Innovation & Implementation.

Table of Contents

EXECUTIVE SUMMARY

Functional Family Therapy (FFT) is one of five prioritized evidence-based practices selected by Maryland's Children's Cabinet with the goals of reducing costly out-of-home placements and providing empirically supported community-based practices that address key youth outcomes (e.g., long-term rates of re-arrest, school attendance, etc.). Since 2007, the Institute for Innovation & Implementation has helped to facilitate FFT implementation in Maryland and provides technical assistance and data reporting to providers and stakeholders.

FY13 Data Highlights

Utilization

- In FY13, FFT was available in 20 jurisdictions throughout Maryland. Based on FY13 funding capacity, Maryland could serve an estimated 930 youth in FFT annually.
- 1,017 youth were referred to FFT in FY13. The majority of referrals were provided by the Department of Juvenile Services (DJS; 80%). Of those youth referred, 70% were admitted for treatment, which was an increase from FY12. Issues regarding youth/family consent and availability were the primary reasons youth did not start FFT.
- The majority of youth admitted to FFT were African American (66%) and male (73%), and the average age of youth admitted to FFT was 16.1 years old. Most youth were involved with DJS upon admission to FFT, and these youth had considerable delinquency histories—on average, youth had more than four prior referrals to DJS. In addition, 41% of youth admitted to FFT had prior involvement with the child welfare system.
- The statewide utilization of FFT, based on funding capacity, was 72%, and utilization based on actual capacity (available slots) was 82%.

Fidelity

- Fidelity to the FFT model has continued to exceed national FFT target scores and has shown improvement since FY11.

Outcomes

- 533 youth were discharged from FFT within the therapist's control in FY13, and **80%** of these youth had completed treatment, which is an improvement over previous years.
- Of youth who completed FFT in FY13, at the time of discharge: **99%** were living at home, **93%** were in school or working, and **98%** had no new arrests.
- Of youth who completed FFT in FY12, as of one year post-discharge:
  - **60%** did <u>not</u> have a new arrest, **88%** had not been convicted, and **93%** had <u>not</u> been incarcerated. Additionally, **89%** had <u>not</u> been placed into a residential placement with DJS.
  - Only **6%** of youth had any new involvement with the child welfare system.

Costs

- In FY13, the average per diem cost of FFT was $34; this compares to an average per diem cost of $210 for group homes, $274 for staff-secure facilities, and $531 for hardware-secure facilities for DJS-involved youth.

Introduction

Purpose of this Report

Functional Family Therapy (FFT) is a widely-recognized evidence-based practice (EBP), designed to help youth with behavior problems and delivered in their homes and communities. In 2007, Maryland's Governor's Office of Children (GOC), on behalf of the Children's Cabinet, Department of Juvenile Services (DJS), and local Departments of Social Services began to work collaboratively to substantially increase the availability of FFT to youth and families in Maryland. Maryland's stakeholders selected FFT with the goals of reducing the use of out-of-home placements while improving outcomes for youth and families across the State.

The Institute for Innovation & Implementation (The Institute) collects and analyzes data to monitor and support FFT implementation in Maryland. This report provides a summary of FFT implementation across the State of Maryland as of fiscal year (FY) 2013. In addition to utilization and fidelity indicators, both short- and long-term outcomes for participating adolescents 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 Functional Family Therapy?

FFT is a short-term, family-based treatment program for youth ages 10 through 18 who are at risk or exhibit delinquent behaviors and substance abuse, as well as school and other conduct problems. The therapeutic model consists of five major phases in addition to pretreatment activities: 1) engagement in change, 2) motivation to change, 3) relational/interpersonal assessment and planning for behavior change, 4) behavior change, and 5) generalization across behavioral domains and multiple systems. Treatment typically includes eight to twelve weekly sessions with the youth and family member(s) over a three- to four-month period. While FFT is a highly structured model, therapy is also individualized to the unique needs and issues of the youth and families served.

More than 30 years of clinical research shows that FFT has positive outcomes across youth from diverse ethnic and cultural backgrounds, including:

- Significant and long-term reductions in youth re-offending and substance use;
- Significant effectiveness in reducing sibling entry into high-risk behaviors;
- High treatment completion rates; and
- Positive impacts on family communication, parenting, and youth problem behavior; reduction of family conflict.

The FFT model has also been successfully implemented across a range of community-based settings and child-serving systems (e.g., Alexander & Parsons, 1973; Alexander, Pugh, Parsons, & Sexton, 2000; Alexander, Waldron, Robbins, & Neeb, 2013; Sexton & Alexander, 2000; Sexton, 2011). For additional information on FFT, please go to www.fftinc.com.

FFT Implementation Support

FFT, Inc. is the national purveyor for FFT and serves over 300 organizations that provide FFT to more than 20,000 families each year. Replication of the evidence-based model with fidelity is achieved using a structured training approach and a sophisticated client assessment, tracking, and monitoring system (FFT-CSS). FFT, Inc. trains, clinically supervises, and provides ongoing support to therapists. In addition to monitoring FFT utilization, fidelity, and outcomes, The Institute facilitates Maryland provider and stakeholder collaborative meetings and works with consultants from FFT, Inc. to ensure the most effective implementation of the model.

What FFT has meant to families in Maryland: Kate's Story

Kate is a 14 year-old girl who lives with her mother. During the initial five months the family participated in FFT, they dealt with a substantial amount of grief related to Kate's court testimony that her mother's boyfriend had acted in a sexually inappropriate manner toward Kate. The resulting rift between mother and daughter was manifested in Kate's poor behavior at school and her argumentative behavior at home. At the end of five months, the family was discharged from the program after Kate attempted suicide and was sent for inpatient treatment.

Six months after their initial discharge, the family was re-referred for to FFT. Kate and her mother were eventually able to enjoy time together and to communicate more effectively with one another. Kate learned different techniques for coping with her strong emotions. She enrolled in a different school, where she earned good grades and was placed on the honor roll. When the family completed treatment four months later, the therapist felt privileged to point out how much they had changed in a year.

Assessing FFT Utilization and Outcomes

The data presented in this report are drawn primarily from youth-level data routinely submitted by Maryland FFT providers. Additional data are provided by 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, reasons for not starting treatment, etc.). As a whole, utilization data indicate the "who, when, and why" for youth referred to and served by FFT.

- ***Fidelity data*** measure the degree to which FFT has been delivered as intended by the program developers.[1]

- ***Outcomes data*** allow us to assess whether FFT has achieved the desired results for youth and families (Table 1). FFT focuses on individual, family, and extra-familial risk and protective factors that impact youth behavior. As such, the outcomes of particular interest in FFT include *increasing protective factors* such as family communication, while *reducing risk factors* such as family conflict, in order to reduce the frequency and number of days spent in out-of-home placements and to reduce the likelihood of delinquent behaviors (Sexton, 2011).

Table 1. FFT Outcome Data—Types and Sources

Type	Indicator	Source
Case Progress	➢ Treatment completion ➢ Reason for non-completion (if applicable)	FFT 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	FFT 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 funding source, provider, and jurisdiction.

[1] All fidelity data are provided by FFT, Inc.

Where was FFT Offered in Maryland?

In FY13, FFT was offered in 20 jurisdictions[2] in Maryland; it was not available in the western region of the State (Figure 1). FFT was administered by three providers (seven FFT teams total)—Baltimore County Bureau of Behavioral Health (two teams), Center for Children (two teams), and VisionQuest (three teams)—for an estimated annual capacity (based on funding) to serve 930 youth.[3] FFT was funded by four sources, including DJS, the Children's Cabinet Interagency Fund (CCIF), a local Department of Social Services (DSS), and Medicaid. Funding sources and slot allocations varied by jurisdiction (see Table 2).

Figure 1. FFT Availability in Maryland, FY13

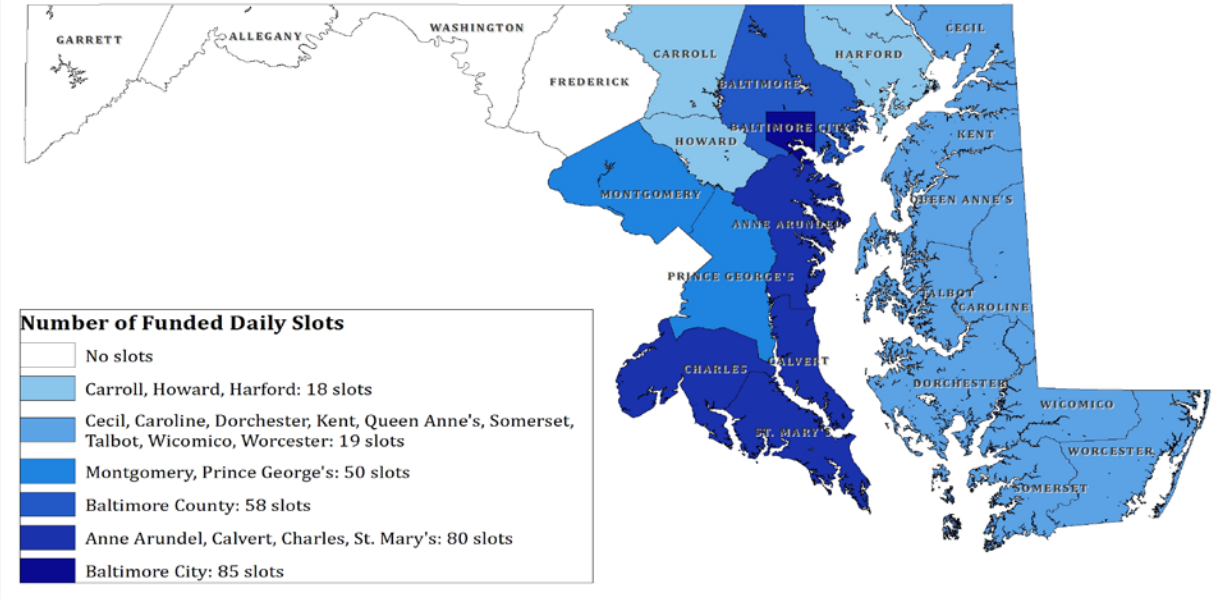


Table 2. FFT Service Provision & Funding Sources in Maryland, FY13

Region (DJS)	Jurisdiction(s) Served	Provider	Funding Source	# Funded Daily Slots
Baltimore	Baltimore City	VisionQuest	DJS	85
Central	Baltimore County	Baltimore County Bureau of Behavioral Health VisionQuest	CCIF DSS DJS	36 18 4
	Carroll, Howard, Harford	VisionQuest	DJS	18
Eastern Shore	Cecil , Caroline, Dorchester, Kent, Queen Anne, Somerset, Talbot, Wicomico, Worcester	VisionQuest	DJS	19
Metro	Montgomery, Prince George's	VisionQuest	DJS	50
Southern	Anne Arundel, Calvert, Charles, St. Mary's	Center for Children	CCIF DJS Medicaid	8 72 --

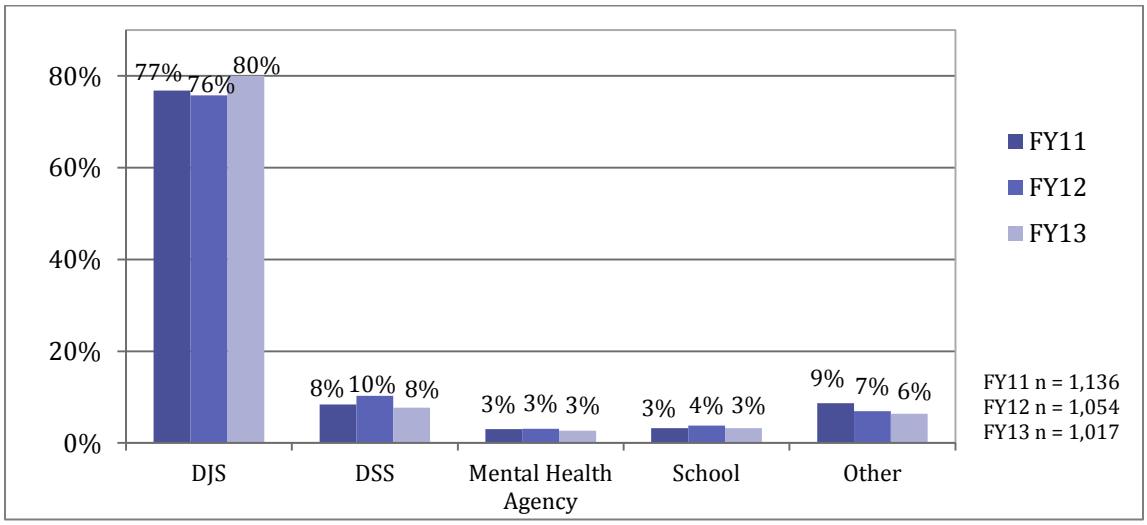
[2] Jurisdictions refer to all Maryland counties and Baltimore City.

[3] The estimated annual capacity is based on the average number of slots funded by DJS, CCIF, and DSS during FY13 (n=310). It assumes that each youth will remain in FFT for an average length of stay of 120 days, and that three youth can be served in each slot during the course of the year.

Referrals to FFT

Maryland youth may be referred to FFT from a variety of sources. In FY13, the majority of the 1,017 referrals were made by DJS (80%), followed by DSS (8%), schools (3%), and mental health/outpatient agencies (3%; Figure 2). Six percent of referrals came from other sources, such as self-referrals from families, hospitals, and other local agencies. DJS has been the principal referral source for FFT in Maryland for the past few years.

Figure 2. FFT Referral Sources, Percentage of Total Youth Referred , FY11-FY13



Characteristics of Referred Youth

FFT can serve male and female youth from diverse racial and ethnic backgrounds between the ages of 10 to 18 years old. In FY13, almost all referred youth met the age criteria for FFT. These youth tended to be older adolescents—approximately two-thirds (65%) were between the ages of 15 and 17 years old (Figure 3) and the average age at referral was 15.9 years old. Sixty-six percent of referred youth were African American/Black, 27% Caucasian/White, 4% Hispanic/Latino, and 3% another race/ethnicity (Table 3). Further, 72% of these youth were male. Characteristics of youth referred to FFT have been fairly constant over the past few years.

Figure 3. Ages of Youth Referred to FFT, FY13

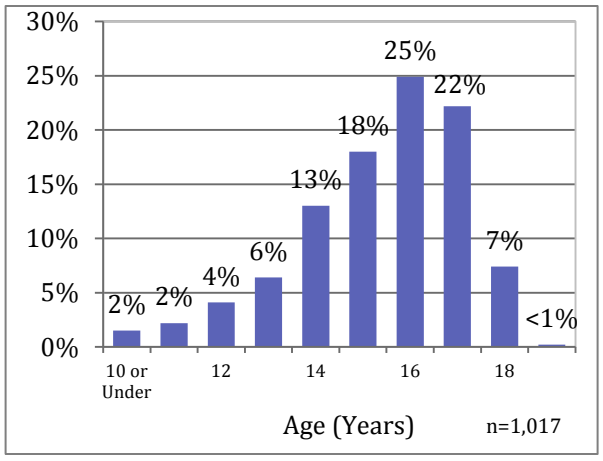


Table 3. Demographic Characteristics of Youth Referred to FFT, FY11-FY13

	FY11	FY12	FY13
Total Number of Youth	1,136	1,054	1,017
Male	826 (73%)	768 (73%)	729 (72%)
Female	309 (27%)	286 (27%)	288 (28%)
African American/Black	767 (68%)	653 (62%)	671 (66%)
Caucasian/White	299 (26%)	297 (28%)	277 (27%)
Hispanic/Latino	34 (3%)	53 (5%)	39 (4%)
Other	36 (3%)	51 (5%)	30 (3%)
Average Age (s.d.)	15.8 (1.9)	15.8 (1.9)	15.9 (1.9)

Referred Youth Who Did Not Start FFT

Not all youth referred to FFT start treatment. In some cases the FFT provider may determine that the youth and/or family are not eligible for FFT, and in other cases the youth/family may be eligible but they choose not to start for another reason. Figure 4 lists the reasons for not starting FFT that are indicated by the providers. These reasons are closely monitored over time as they offer important information about how to improve the admission process, including how to increase appropriate referrals and decrease barriers to treatment engagement. Ultimately, utilization is highly dependent on a sufficient flow of referrals for eligible youth and families who could benefit from FFT.

Figure 4. Reasons for Not Starting FFT

Youth may not start FFT due to exclusionary factors that make them **ineligible** for participation, including:

- *Age appropriateness;*
- *Suicidal, homicidal, or psychotic issues;*
- *Diagnosed with autism, pervasive developmental delay, mental retardation, or with an IQ less than 75;*
- *Diagnosed primarily as a sex offender;*
- *No psycho-social system/ identifiable caregiver;*
- *Scheduled to be sent away from the family;*
- *Already completed a full course of FFT treatment; or*
- *Unavailable (AWOL, detained).*

Youth may not start FFT despite being **eligible** because:

- *The referral/funding source rescinded the referral;*
- *The youth and/or parent/ guardian do not consent;*
- *The family cannot be contacted; or*
- *The family is outside of the service area.*

The percentage of referred youth who did not start FFT decreased from 38% in FY11 to 31% in FY12 and 30% in FY13. The majority of these youth were eligible for FFT, including 234 youth in FY12 and 201 youth in FY13 (Figure 5). Figure 6 shows the specific reasons that youth did not start FFT in FY13. The most frequent reason was *unable to contact family* (30%), followed by the *youth and/or parent/guardian do not consent* (21%). In total, reasons related to youth and family unwillingness or unavailability accounted for 51% of those who did not start, representing a slightly smaller share from the previous year (56%). Even so, a lack of youth and family engagement at the beginning of treatment remains an important issue.

Figure 5. Eligibility of Youth/Families who Did Not Start FFT, FY12-FY13

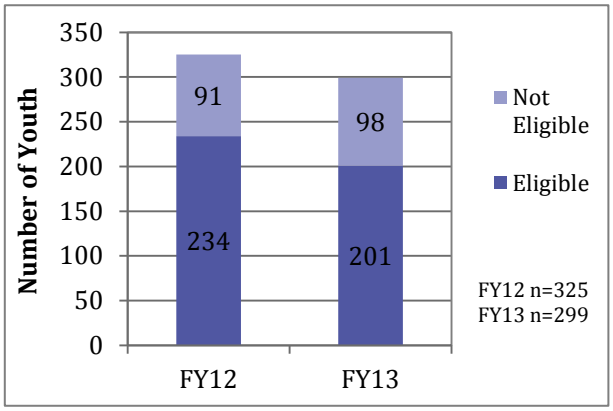
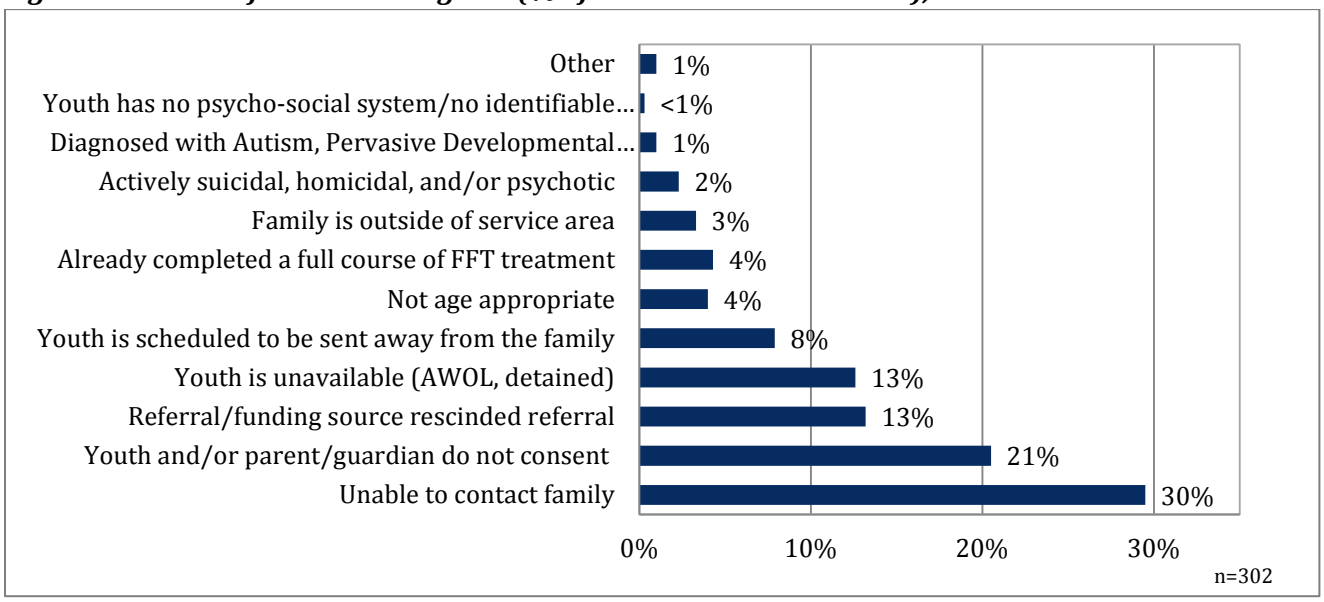


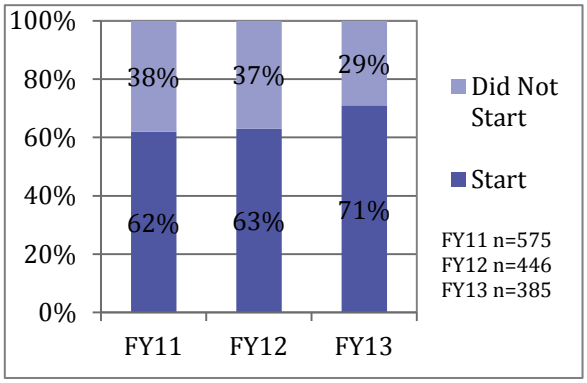
Figure 6. Reasons for Not Starting FFT (% of Youth who Did Not Start), FY13



Waitlisted Youth

In FY13, 385 youth were placed on the waitlist—down from 575 in FY11 and 446 in FY12. The characteristics of youth on the waitlist were similar to those referred, with 69% male (compared with 72% of referred youth) and 61% identified as African American/Black (compared with 66% of referred youth). The percentage of youth who were placed on the waitlist and ultimately did not start FFT has declined over the past few years, from 38% in FY11 to 29% in FY13 (Figure 7). Note that youth can be waitlisted even when the program is not fully utilized due to reductions in available therapists (i.e., slots).

Figure 7. Percentage of Youth Admitted to FFT from the Waitlist, FY11-FY13



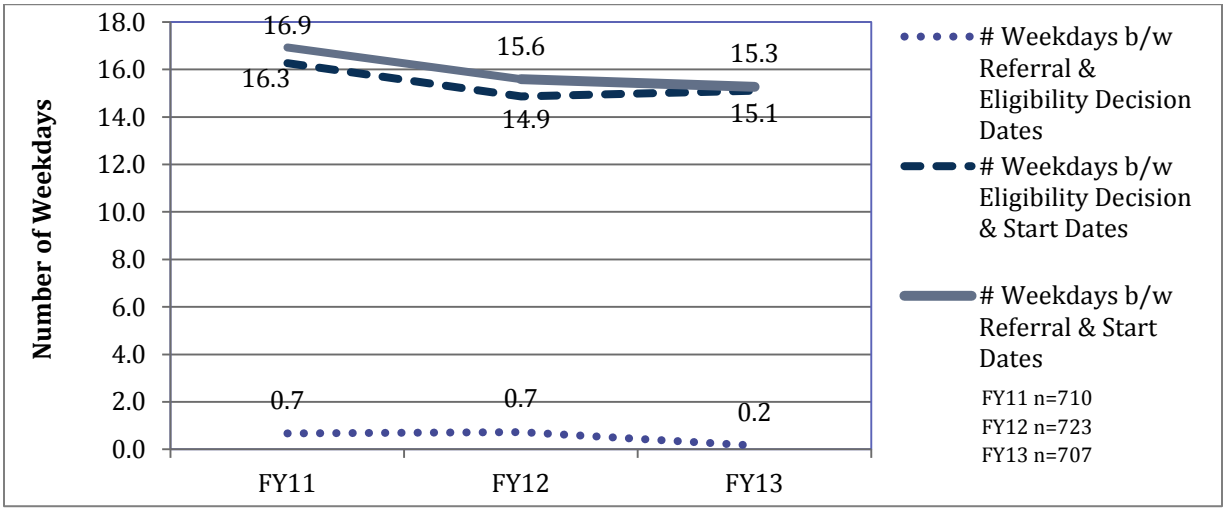
Admissions to FFT

Global Admission Length (Initial Case Processing)

Once a youth is referred to FFT, it is critical that an eligibility decision is made in a timely manner and that treatment starts soon thereafter. FFT providers report referral, eligibility decision, and start dates, so this process can be closely monitored. The number of days between the referral and start dates is referred to as the *global admission length*.

Global admission length has declined slightly over the past three years (Figure 8). In FY13, providers generally made an eligibility decision within one weekday of receiving the referral, and youth typically started treatment within approximately three weeks (15 weekdays) of this decision.

Figure 8. Global Admission Length, FY11-FY13*



**GAL includes any time youth spent on the waitlist.*

There were a number of statistical differences in the global admission length by subgroups of youth (see Table 4; only significant differences shown), as well as differences across agencies and jurisdictions (Appendix 1). Notably, youth whose participation in FFT was funded by DJS had a significantly shorter global admission length (12.6 days) than youth who were funded by DSS (20.7 days) and the CCIF (36.8 days).

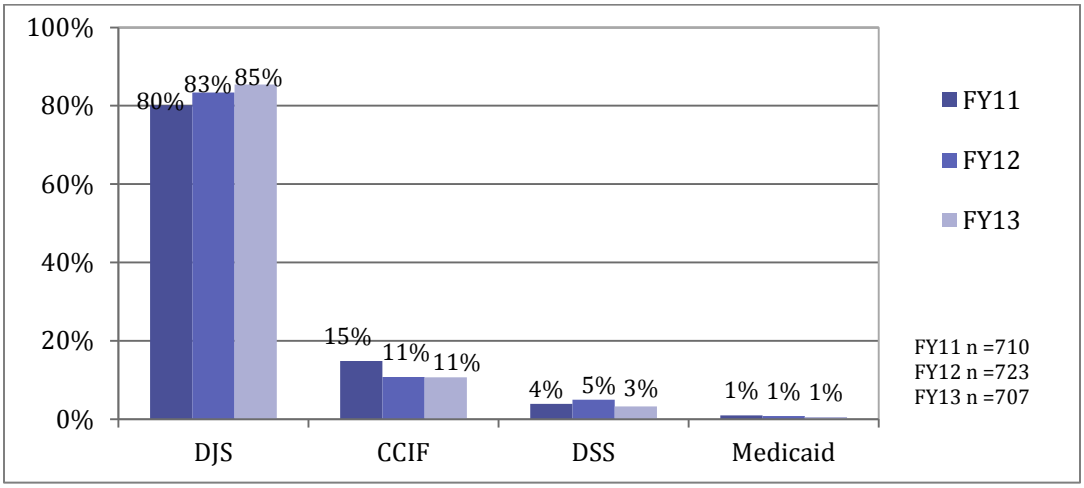
Table 4. Statistically Significant Differences in Global Admission Length* (GAL; days)

Factor	Shorter GAL	Longer GAL
Gender	Male (14.5)	Female (17.4)
Age at Admission	15 years and older (14.1)	Under 15 years old (19.2)
Prior Referrals to DJS	Yes (12.8)	No (31.2)
Prior DJS Commitments	Yes (12.2)	No (16.3)
Funding Source	DJS (12.6)	DSS (20.7) CCIF (36.8)
Waitlisted	No (7.1)	Yes (28.7)

Utilization

Overall, 707 youth were admitted to FFT in FY13, a slight decrease from FY12 (n=723). Despite this small reduction, the percentage of youth admitted has remained consistent (69% in FY12 and 70% in FY13). DJS has been the primary funding source for FFT during the past few years and, accordingly, the majority of youth admitted to FFT in FY13 were funded by DJS (85%), followed by CCIF (11%), and DSS (3%; Figure 9). Just one percent of youth were funded through Medicaid.

Figure 9. FFT Funding Sources, Percentage of Youth Admitted, FY11-FY13



Given the significant investment to make FFT available to youth and families across Maryland, it has been critical to all stakeholders that the available slots are utilized to their maximum capacity. FFT utilization reflects the number of youth who are admitted to treatment, as well as the length of time that youth and families remain in treatment (see page 16 for descriptive statistics related to length of stay), divided by the number of slots. Utilization is calculated based on funding capacity (i.e., funded slots) and actual capacity (i.e., active slots), which accounts for the availability of therapists (e.g., if the therapist is out on leave or away for training, or a position is vacant). These factors are tracked closely during the year by providers and referral/funding sources to ensure that FFT is reaching as many youth and families as possible.

In FY13, DJS, CCIF, and DSS collectively funded a daily capacity of 310 FFT slots across Maryland (Table 5). Of these slots, an average of 272 was "active", or available to youth and families for treatment. The average daily census of youth served by FFT was 224. Therefore, the average statewide utilization of funded slots was 72% and utilization for active slots was 82%. Both of these percentages represent slight improvements over FY12, when the average statewide utilization of funded slots was 71% and utilization for active slots was 79%. The remainder of this section describes the types of youth who participated in FFT.

Table 5. FFT Utilization, FY12-FY13

	FY12	FY13
Average Number of Funded Slots (Daily)	323	310
Average Number of Active Slots (Daily)	290	272
Average Daily FFT Census	230	224
Average Utilization of Funded Slots	71%	72%
Average Utilization of Active Slots	79%	82%

Characteristics of Admitted Youth

The characteristics of youth admitted to FFT were similar to those of the referral population. Most youth admitted to FFT in FY13 were between the ages of 15 and 17 years old (67%; Figure 10), and their average age was 16.1 years old. The majority of youth were male (73%) and African American/Black (66%; Table 6). The characteristics of youth admitted to FFT have remained relatively stable over the past few years.

Figure 10. Ages of Youth Admitted to FFT, FY13

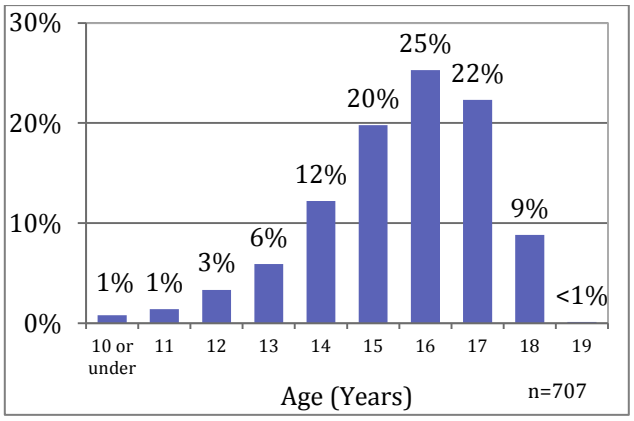


Table 6. Demographic Characteristics of Youth Admitted to FFT, FY11-FY13

		FY11	FY12	FY13
	Total Number of Youth	710	723	707
Gender	Male	510 (72%)	538 (74%)	515 (73%)
	Female	200 (28%)	185 (26%)	192 (27%)
Race/Eth.	African American/Black	476 (67%)	455 (63%)	466 (66%)
	Caucasian/White	192 (27%)	182 (25%)	192 (27%)
	Hispanic/Latino	23 (3%)	51 (7%)	33 (5%)
	Other	19 (3%)	35 (5%)	16 (2%)
	Average Age (s.d.)	16.0 (1.8)	16.1 (1.7)	16.1 (1.7)

Involvement with DJS

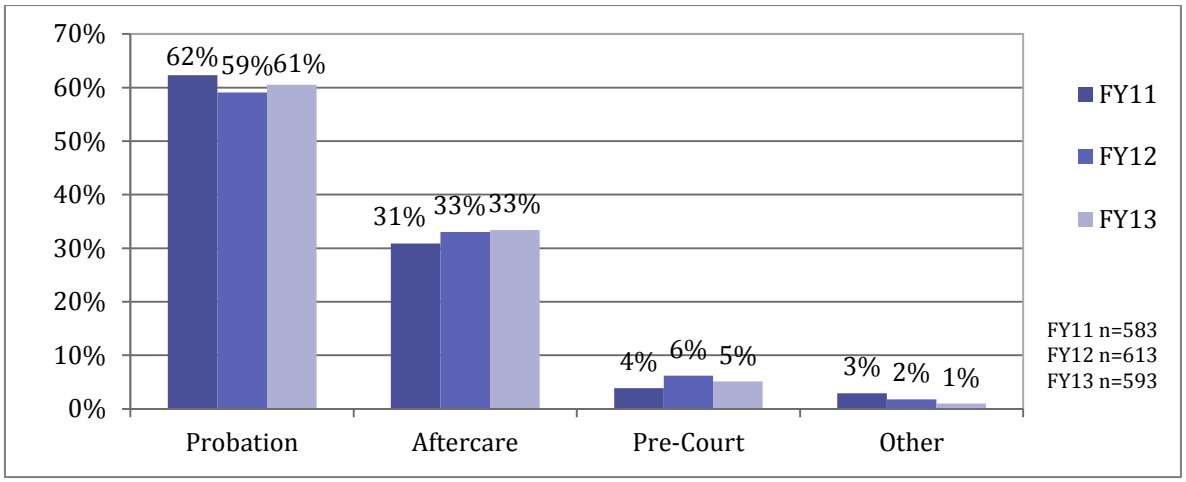
Consistent with patterns seen in the previous two fiscal years, 86% of youth admitted to FFT in FY13 had at least one prior referral to DJS (Table 7). Of those with previous DJS involvement, youth had, on average, more than four prior DJS referrals, and their mean age at first referral was 13.9 years old. Slightly more than one-quarter (26%) of admitted youth had at least one prior commitment to DJS, and this subset of youth averaged 1.5 prior commitments.

Table 7. Prior DJS Involvement for Youth Admitted to FFT, FY11-FY13

	FY11	FY12	FY13
Total Number of Youth	710	723	707
One or More Prior DJS Referrals	600 (85%)	628 (87%)	611 (86%)
Avg. # of Prior DJS Referrals (s.d.)	4.8 (3.7)	4.6 (3.7)	4.1 (3.2)
Avg. Age at First DJS Referral (s.d.)	13.8 (1.9)	13.9 (2.0)	13.9 (1.9)
One or More Prior DJS Commitments	141 (20%)	162 (22%)	180 (26%)
Avg. # of Prior DJS Commitments (s.d)	1.7 (1.1)	1.6 (1.1)	1.5 (0.9)

Eighty-four percent of the admitted youth had some form of active involvement with DJS (Figure 11). Of these, 61% were under probation supervision, 33% aftercare supervision (i.e., committed to DJS), 5% pre-court supervision, and 1% were under another form of supervision (e.g., administrative). Of youth under probation or aftercare supervision, 24% were 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. Further, 85 youth (15% of youth under aftercare or probation supervision) had been released from a committed residential placement within 30 days of starting FFT.

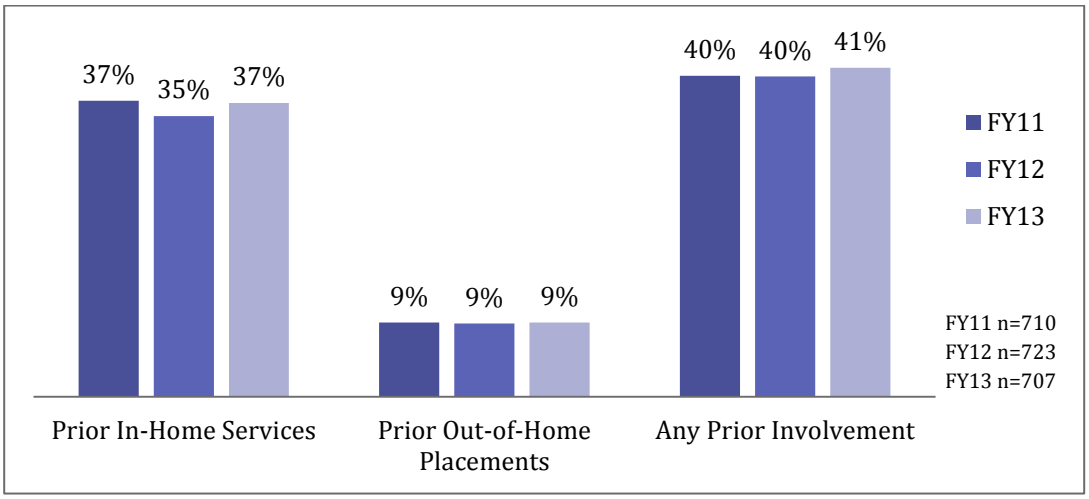
Figure 11. DJS Supervision for Youth Admitted to FFT, FY11-FY13



Involvement with DSS

Of the 707 youth admitted to FFT in FY13, 289 (41%) had some form of prior contact with the child welfare system (Figure 12). Prior to being referred to FFT, 65 youth (9%) had been placed out-of-home and 258 (37%) had received in-home services. On average, youth were 6.2 years old at the time of their first out-of-home placement and 7.2 years old at the time of their first in-home service.[4]

Figure 12. Prior DSS Involvement for Youth Admitted to FFT, FY11-FY13



[4] Average age at first in-home service is based on 256 cases; two cases were excluded due to negative age values.

Simple bivariate analyses were conducted to determine if youth who started FFT differed from those who did not start. These findings are summarized in Figure 13. Notably, older youth, Hispanic/Latino youth, and those with prior DJS involvement were more likely to start FFT in FY13. Also note that rates of admission varied substantially by provider agency and jurisdiction; these figures can be found in Appendix 1.

Figure 13. Factors Related to Starting FFT

Youth who started FFT were statistically <u>more likely</u> to:

- ✓ Have DJS funding for FFT
- ✓ Be older at the time of referral
- ✓ Have one or more prior DJS referral
- ✓ Be Hispanic/Latino

Starting FFT was not statistically related to:

- x Gender
- x Having one or more prior DJS commitments
- x Having prior DSS involvement

FFT Model Fidelity

If youth and families are to be helped, FFT must be delivered in the way it was designed and with a high degree of clinical skill. One study conducted in Washington State demonstrated that youth treated by therapists who implemented FFT with high adherence had dramatically better outcomes than the service control group. In contrast, youth who had therapists with low adherence did worse than the control group (Barnoski, 2002). Fidelity to the FFT model is critical for successful implementation, and it is especially important to monitor fidelity when an EBP is scaled up for a large population.

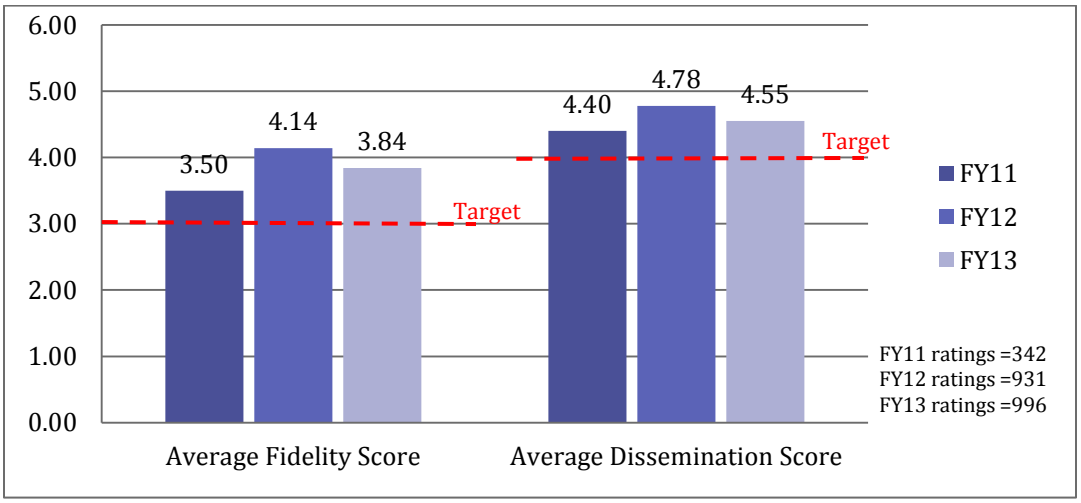
Two primary measures are utilized to assess FFT Fidelity—the *Average Fidelity Score* and the *Average Dissemination Adherence Score*.

- The ***Average Fidelity Score*** evaluates the therapist's application of the model's clinical components. At weekly case staffing meetings, FFT clinical supervisors use standardized assessments to rate each FFT therapist on levels of model adherence (application of necessary technical and clinical aspects of FFT) and competence (skillful application of the necessary components of FFT). *Model fidelity* is represented by summating these two rating scales; this summated score is averaged across a 12-week period and can range from 0 to 6. **The target Average Fidelity Score is 3.**

- The ***Average Dissemination Adherence Score*** rates the therapist's execution of the administrative components of delivering FFT. *Dissemination Adherence* is the degree to which the therapist is doing the FFT *<u>program</u>* (assessment protocol, attendance in supervision, completing documentation using the web-based system). The ratings are based on the degree to which the therapist is completing all of the notes in a thorough manner (e.g., in a way that is useful to them in reviewing and planning), scheduling sessions in a way that is responsive and flexible, and administering assessments when appropriate. **The Average Dissemination Adherence Score can range from 0 (none) to 6 (always), and the target score is 4.**

Figure 14 illustrates the *Average Fidelity* and *Average Dissemination Adherence Scores* for all FFT teams in Maryland between FY11 and FY13. Both measures indicate a slight decline in scores over the past year; however, the teams continue to surpass the target scores.

Figure 14. FFT Provider Fidelity & Dissemination Adherence, FY11-FY13



FFT Discharges & Outcomes

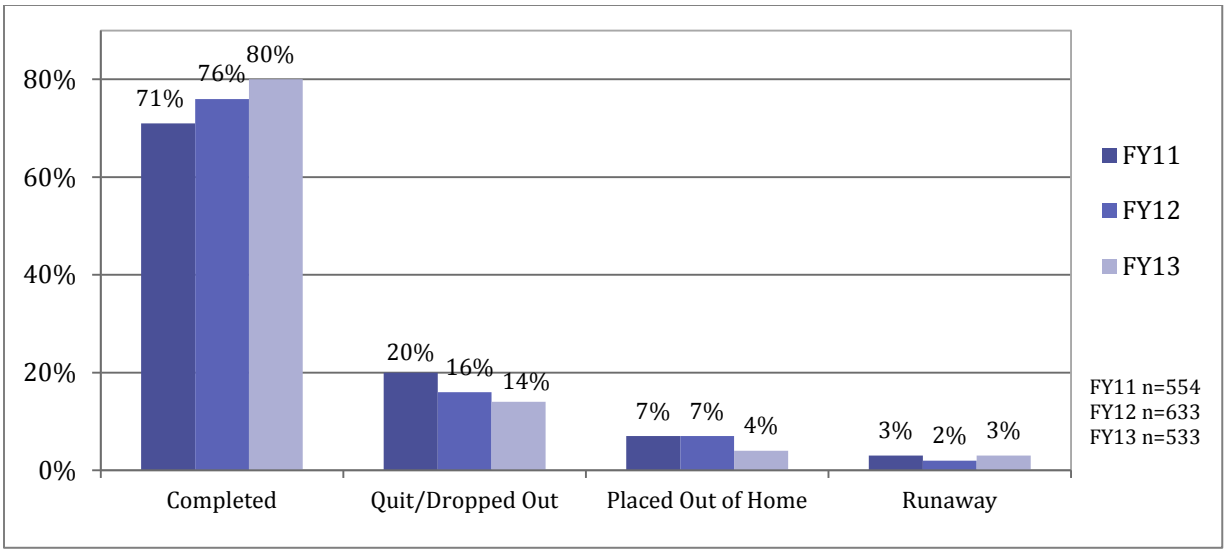
Of the 630 youth who were discharged from FFT in FY13, 533 (85%) were discharged for reasons *within therapist control*. The remaining 15% of cases were discharged for reasons *outside of therapist control* (note that these cases will not be included in subsequent analyses). The specific discharge reasons falling under each category are listed in Figure 15.

Figure 15. Discharge Reasons

Within Therapist Control	Outside of Therapist Control
➢ Completed treatment	➢ Youth/family moved
➢ Quit/dropped out after contact	➢ Youth referred to other services
➢ Youth ran away	➢ Administrative reasons
➢ Youth was placed out-of-home (for a new event during FFT)	➢ Youth was placed out-of-home (for an event prior to FFT)

As shown in Figure 16, the majority of youth completed FFT (80%, n=424), and this outcome has improved as compared with previous cohorts (71% in FY11 and 76% in FY12). Of those who did not complete treatment, the most common reasons were that the *youth/family quit or dropped out* (14%) and the *youth was placed out-of-home for a new event during FFT* (4%; out-of-home placements include, but are not limited to, substance abuse inpatient programs, group homes, or therapeutic group homes). In another 3% of cases the *youth ran away*.

Figure 16. Discharge Reasons for Youth Discharged within Therapist Control from FFT, FY11-FY13

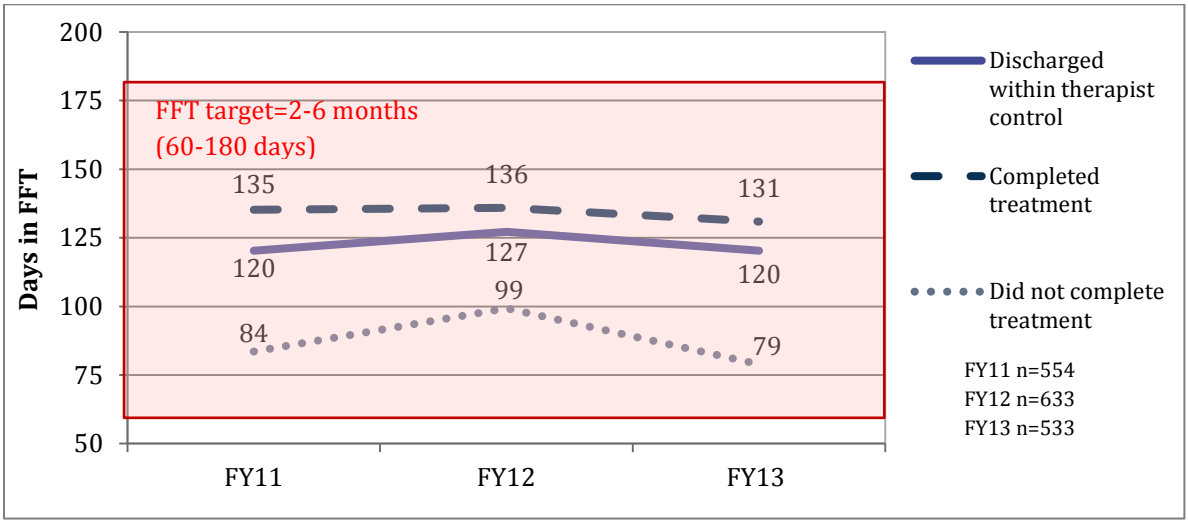


Preliminary analyses reveal some significant differences between youth who completed FFT and those who did not (of youth discharged within the therapist's control). Notably, African American/Black youth were less likely to complete FFT (75%) compared with Caucasian/White youth (87%) and youth of other races/ethnicities (92%). There were also substantial variations by funding source, provider agency, and jurisdiction (see Appendix 1).

Length of Stay

The average length of stay (ALOS) in FFT treatment was 120 days, meeting the national purveyor's target of 60-180 days (Figure 17). ALOS was significantly longer for youth who completed treatment (131 days), as compared with those who did not complete (79 days).

Figure 17. Length of Stay in FFT, FY11-FY13



The length of stay in FFT treatment was related to several youth characteristics (Table 8). Of those discharged within therapist control, the following types of youth had significantly longer lengths of stay: Caucasian/White youth, those who were younger, youth who had no prior DJS referrals, those who had no

prior DJS commitments, and those placed on the waitlist. Again, length of stay varied substantially by funding source, agency, and jurisdiction. Gender and prior DSS involvement were not statistically related to length of stay.

Table 8. Statistically Significant Differences in Lengths of Stay (LOS; days)

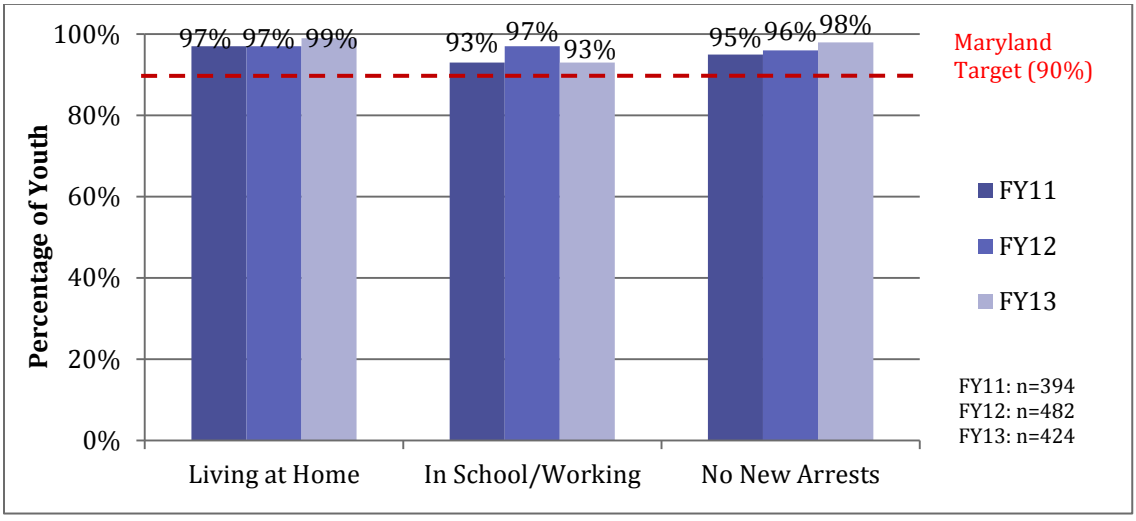
Factor	Shorter LOS	Longer LOS
Race/Ethnicity	African American/Black (113.6) Hispanic/Latino (106.1)	Caucasian/White (135.2) Other (209.4)
Age at Admission	15 years and older (113.8)	Under 15 years old (141.4)
Prior Referrals to DJS	Yes (113.1)	No (170.0)
Prior DJS Commitments	Yes (108.2)	No (124.2)
Funding Source	DJS (112.5)	CCIF (164.7) DSS (180.9)
Waitlisted	No (115.5)	Yes (130.2)

Ultimate Outcomes at Discharge

Even though most youth completed FFT, 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 18 shows the ultimate outcomes for youth who completed FFT over the past three years. FFT has a target of 90% success for each ultimate outcome, and this goal has been achieved in each of the three years. Further, 90% of completers in FY13 had positive results for all three outcomes. Success for all three outcomes was significantly more likely for youth who were younger at the time of admission. Gender, race/ethnicity, prior DSS involvement, and prior DJS involvement were not statistically related to this successful outcome.

Figure 18. Ultimate Outcomes at Discharge for Youth who Completed FFT, FY11-FY13



DJS Involvement during Treatment

The ultimate outcomes are reported by FFT therapists, who may not be aware of all youth contacts with law enforcement or the 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, 19% of youth had been referred to DJS/arrested while receiving FFT in FY13 (of completers)—compared with the reported 2% who had new arrests upon discharge. In addition, DJS data show that 12% of youth were admitted to a DJS detention facility during treatment.

Longitudinal Outcomes

Subsequent Involvement with the Juvenile and/or Criminal Justice System

Research has demonstrated that participation in FFT is associated with a reduced risk for delinquency and criminal behavior. In order to assess these longitudinal outcomes, The Institute provided DJS and DPSCS with the name, gender, race/ethnicity, and date of birth of *all* youth who were discharged from FFT in FY10, FY11 and 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). Youth who had been placed in secure juvenile residential facilities (e.g., detention, Youth Center) as of discharge from FFT were excluded from the analysis (two youth in FY10, seven youth in FY11, and eleven youth in FY12).[5]

Juvenile & Criminal Justice System Recidivism 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.

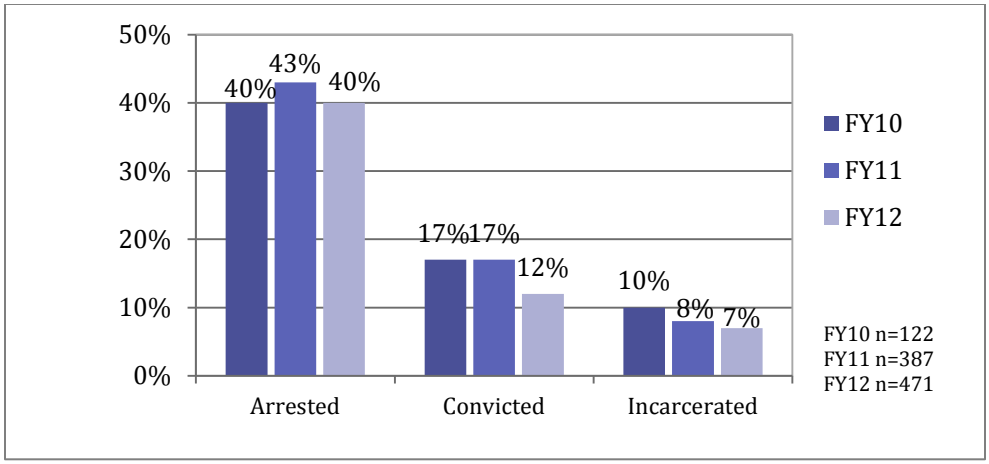
Incarcerated refers to any commitment to DJS custody as a result of a complaint that is adjudicated delinquent, as well as incarceration in the adult system that results from an adult arrest and conviction.

The majority of youth who completed FFT in FY10, FY11, and FY12 avoided subsequent contact with the juvenile and/or criminal justice systems within one year of discharge (Figure 19). Approximately two-fifths of treatment completers were arrested within one year (40% for the FY10 cohort, 43% for FY11, and 40% for FY12); however, far fewer youth were ultimately convicted (17% for FY10 and FY11, and 12% for FY12) and incarcerated for these offenses within one year (10% for FY10, 8% for FY11, and 7% for FY12). There has also been a slight decline in post-discharge arrest, conviction, and incarceration rates in the most recent discharge cohort.

According to bivariate analyses using FY12 completers, males and those with a prior DJS referral were significantly more likely to be arrested within one year following their FFT discharge. Age, race/ethnicity, having a prior DJS commitment, and prior DSS involvement were not statistically related to having a subsequent arrest.

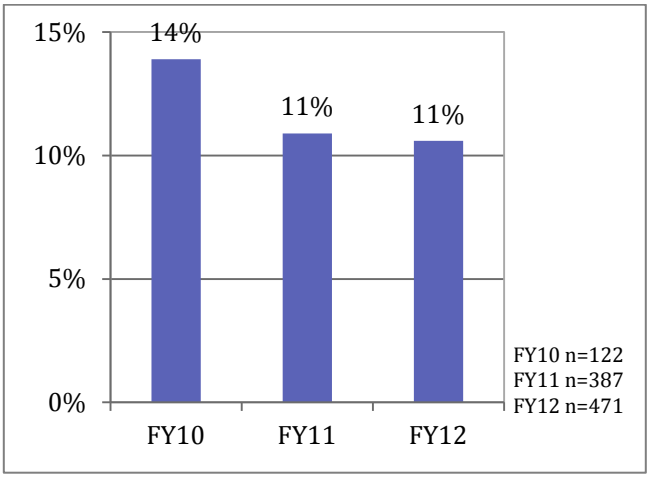
[5] Because incarceration dates are not provided in the data attained from DPSCS, the analyses presented here cannot exclude youth who were in adult facilities at the time of their discharge from FFT.

Figure 19. Juvenile and/or Criminal Justice Involvement within 12 Months Post-Discharge, Youth who Completed FFT, FY10-FY12



New Residential Placement with DJS. Youth who are committed to DJS do not need to commit a new offense and be processed through the juvenile court in order to be placed in a residential facility. Consequently, more youth may be admitted to a new residential placement following discharge from FFT than indicated by rates of commitment (shown above). Of the 122 youth who completed FFT in FY10, 14% were admitted to a residential placement[6] by DJS during the twelve months following discharge (Figure 20). By comparison, 11% of the youth who completed FFT in FY11 (n=389) and FY12 (n=471) were admitted to a new residential placement within one year.[7] The most frequent types of placements included Youth Centers (38%; n=19), in-patient substance abuse programs (24%; n=12), and therapeutic and other group homes (18%; n=9).

Figure 20. New DJS Residential Placement within 12 Months Post-Discharge, Youth who Completed FFT, FY10-FY12



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-FFT discharge. Overall, very few FFT completers had subsequent contact with the child welfare system. Of 482 youth who completed FFT in FY12, 6% had some form of new DSS contact within 12 months of discharge—11 (2%) had a new DSS investigation, 17 (4%) received in home services, and only three (1%) were placed out-of-home within twelve months of discharge from FFT (Table 9).

[6] Residential placements include places such as Youth Centers, group homes, residential treatment facilities, treatment foster care, etc. It does not include detention.

[7] These percentages do not include youth who were residing in a secure facility at discharge from FFT.

Table 9. DSS Involvement within 12 Months Post-Discharge, Youth who Completed FFT, FY10-FY12

	FY10	FY11	FY12
Total Number of Youth	124	394	482
New DSS Involvement	4 (3%)	24 (6%)	27 (6%)
Investigation	2 (2%)	13 (3%)	11 (2%)
In-Home Service	3 (2%)	11 (3%)	17 (4%)
Out-of-Home Placement	1 (1%)	7 (2%)	3 (1%)

Cost Analysis

FFT provides an opportunity to not only help youth but to save money when it can be used to prevent the costs of more expensive placements. The costs of serving youth with FFT (DJS-funded youth only) were compared with the costs for placing youth in DJS residential care in FY13 (Table 10). The average per diem cost of FFT was $34 compared to an average of $210 for group homes, $274 for staff-secure facilities, and $531 for hardware-secure facilities. While the average costs per stay were over $43,000 for group homes, nearly $34,000 for staff-secure facilities and almost $84,000 for hardware-secure facilities, the average cost per FFT intervention per child was approximately $3,800.

Table 10. Cost Comparison: FFT versus Other DJS Residential Placements, FY13

	Average Length of Stay/ Treatment (Days)	Per Diem Cost	Average Cost per Stay/ Treatment
FFT	113	$34	$3,814
Group Homes	206	$210	$43,283
Staff-Secure Facilities	123	$274	$33,573
Hardware-Secure Facilities	157	$531	$83,535

Notes: (1) Calculations for Group Homes, Staff Secure, and Hardware Secure facilities are based on data provided by DJS; these data include only DJS facilities in Maryland. (2) Per diem costs include ongoing training and fidelity monitoring cost; costs for educational services have been subtracted from Staff Secure and Hardware Secure Facility costs.

FY13 FFT Implementation in Maryland: Successes & Challenges

Utilization

- The percentage of referred youth who started FFT increased in FY13; youth referred by DJS are significantly more likely to start treatment as compared with youth funded through DSS or CCIF.
- A total of 151 youth did not start FFT because the youth or family did not consent to treatment or they were unavailable. Greater effort should be expended to educate parents on the goals of the program and to encourage participation.
- The average utilization rate for funded FFT slots was 72% and 82% for active slots. Although improving over the past fiscal year, utilization continues to fall under the 90% target for the state.
- The global admission length has slightly declined over time, and, on average, youth and families started treatment within three weeks of referral during FY13. There are, however, significant differences in global admission length between slots funded by DJS compared to other funding sources, warranting a closer look into possible differences in the process.
- A diverse population of girls and boys from different racial and ethnic backgrounds were referred and admitted to FFT. However, there has been an identified need for more availability of Spanish-speaking therapists to better serve Spanish-speaking families.
- The percentage of youth who were placed on the waitlist and ultimately did not start FFT has declined over the past few years.

Fidelity

- The *Average Fidelity Score* and the *Average Dissemination Adherence Score* both decreased from FY12 to FY13, but both average scores still exceeded the FFT national target.
- The average length of stay in FFT was 120 days, well within the national purveyor's target of 60-180 days.

Outcomes

- Eighty percent of discharged youth completed treatment in FY13, which represents a notable improvement as compared with discharge cohorts from the previous two fiscal years. However, significantly fewer African-American/Black youth completed treatment relative to Caucasian/White youth; reasons for these results should be explored.
- For a third year in a row, youth who completed FFT have exceeded the target goal of 90% on each of the ultimate outcomes (i.e., living at home, in school/working, and no new arrests at discharge), and 90% achieved success for all three of the outcomes as of discharge.
- Compared to FY11 completers, smaller percentages of FY12 completers were arrested, convicted, or incarcerated during the twelve months following their discharge from FFT.
- Approximately 90% of the youth who completed FFT were not subsequently admitted to a DJS residential facility in year following treatment completion.
- Very few youth who completed FFT in FY12 (6%) had new involvement with DSS in the year following discharge.

References

Alexander, J., & Parsons, B. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81(3)*, 219-225.

Alexander, J. F., Pugh, C, Parsons, B, F., & Sexton, T. (2000). Functional family therapy (Book Three: Vol II). In D. S. Elliott, (Series Ed.). *Blueprints for Violence Prevention*. Institute of Behavioral Science, Regents of the University of Colorado.

Alexander, J.F., Waldron, H.B., Robbins, M.S., & Neeb, A.A. (2013). *Functional family therapy for adolescent behavior problems*. Washington, DC: American Psychological Association.

American Psychological Association. (2002). Criteria for evaluating treatment guidelines. *American Psychologist, 57(12)*, 1052-1059.

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61(4),* 271-285.

Barnoski, R. (2002). *Washington State's implementation of functional family therapy for juvenile offenders: Preliminary findings*. Olympia, WA: Washington State Institute for Public Policy.

Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, E. (2005). *Implementation research: A synthesis of the literature.* Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.

Sexton, T. L. (2011). *Functional family therapy in clinical practice.* New York, NY: Routledge.

Sexton, T. L., & Alexander, J. F. (2000). *Functional family therapy*. Juvenile Justice Bulletin. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. http://www.surgeongeneral.gov/library/mental health.