FUNCTIONAL FAMILY THERAPY
MARYLAND STATE
FY11 ANNUAL REPORT

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

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Executive Summary

Functional Family Therapy (FFT) is one of five prioritized evidence-based practices chosen by Maryland's Children's Cabinet for statewide implementation in an effort to reduce costly out-of-home placements and provide empirically supported community-based practices that address key outcomes (e.g., long-term rates of rearrest, school attendance, etc.). Maryland's FFT program data for fiscal year (FY) 2011 indicate that a diverse group of 866 youth and families received FFT, and that the majority of youth had positive outcomes at discharge from FFT. Further, only a small percentage of youth who received services were ultimately committed to the Maryland Department of Juvenile Services (DJS) because of a new referral or arrest after discharge from FFT.

The number of youth served by FFT in Maryland increased from 370 in FY10 to 866 served in FY11— a 134% increase in one year.

Most notably, among those youth who were discharged from FFT in FY11:

- **84%** were living at home;
- **87%** were in school or working ; and
- **87%** had no new arrests as of discharge.

Further, among youth who were discharged from FFT in FY10, as of one year after discharge:

- **62%** did not have a new arrest or DJS referral;
- **92%** had not been committed to DJS or incarcerated; and
- **85%** were not placed in a new residential placement with DJS.

Compared with demographically similar DJS youth discharged from group homes in FY10:

- FFT youth who were also under DJS supervision were less likely to be arrested (52% vs. 58%), but more likely to be adjudicated delinquent/convicted (21% vs. 11%) and committed to DJS/incarcerated (12% vs. 7%).

Completion rates for FFT are nearing 70%, which is the national FFT target for phase I teams. With many of the FFT teams being newly established in 2010 and 2011, these completion rates are comparable to national standards. FFT national consultants are working with providers to increase engagement with families, fidelity to the model, and frequency of sessions to ultimately increase successful completion rates. Though more research is necessary to clearly determine how FFT compares to other treatment options available in Maryland for delinquent youth, these preliminary results suggest FFT is a viable option in Maryland for diversion from out-of-home placements.

Introduction

What is the Purpose of this Report?

The purpose of this report is to provide state and local stakeholders and vendors with a summary of Functional Family Therapy (FFT) utilization and outcomes across the state of Maryland during fiscal year (FY) 2011. FFT is one of five prioritized Evidence-Based Practices (EBPs)[1] chosen by Maryland's Children's Cabinet for statewide implementation in an effort to reduce costly out-of-home placements and provide field-tested, community-based practices shown to address important youth outcomes (e.g., family functioning, school attendance, association with deviant peers, long-term rates of rearrest). Both short- and long-term effects of this EBP for high-risk, neglected, and/or delinquent adolescents are examined.

Child and family evidence-based practice implementation and evaluation in Maryland

Under contract with the Governor's Office for Children (GOC) on behalf of the Maryland Children's Cabinet, The Institute for Innovation and Implementation's (The Institute) research and evaluation team serves as the data collection center for the State in order to track a variety of EBPs being utilized throughout Maryland. Guided by the Children's Cabinet, the research and evaluation team collects data from local EBP providers, as well as from national purveyor databases (when possible) and state agencies, to routinely report on EBP implementation, including: where services are available and at what capacity, how services are funded, how services are utilized, how well services are being delivered based on model requirements, and outcomes for youth following treatment discharge.

Definitions

What is an evidence-based practice?

An evidence-based practice refers to 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.

*An **evidence-based practice** is the integration of the best available research with clinical expertise in the context of youth and family characteristics, culture, and preferences.*

[1] The prioritized EBPs chosen by Maryland's Children's Cabinet include Brief Strategic Family Therapy, Functional Family Therapy, Multidimensional Treatment Foster Care, Multisystemic Therapy, and Trauma-Focused Cognitive Behavioral Therapy.

What is Functional Family Therapy?

Functional Family Therapy (FFT) is a highly successful family intervention for at-risk youth ages 10 through 18 whose problems range from acting out to conduct disorder to alcohol and/or substance abuse. The intervention consists of five major components, in addition to pretreatment activities: engagement in change, motivation to change, relational/interpersonal assessment and planning for behavior change, behavior change, and generalization across behavioral domains and multiple systems. FFT has demonstrated positive program outcomes across a wide range of youth and communities, including:

- Significant and long-term reductions in youth re-offending and violent behavior;
- Significant effectiveness in reducing sibling entry into high-risk behaviors;
- Low treatment drop-out and high treatment completion rates; and
- Positive impacts on family conflict, family communication, parenting, and youth problem behavior.

The FFT model has been successfully replicated across a range of child-serving systems, from prevention- and diversion-type programs to aftercare and probation, as well as traditional substance abuse and school-based programs.

FFT targets at-risk youth whose problems range from acting out to conduct disorder to alcohol and/or substance abuse.

Assessing FFT Utilization and Outcomes

Data

The data reported in this document were drawn from multiple sources. The primary sources were FFT vendors in Maryland, who routinely submit youth-level data from a basic demographic and utilization measure developed by The Institute for Innovation and Implementation.[2] With any large-scale implementation and evaluation effort, collecting accurate data is an ongoing process. Throughout this process, the research and evaluation team works closely with providers to establish clear, consistent guidelines about the data collected, ensuring that reports accurately reflect the quality practices that providers deliver. The data presented in this report were accessed in October 2011.

Two State Agencies[3] also provided data in order to better describe the youth who were referred and served by FFT, as well as to create additional post-discharge outcome measures (e.g., recidivism). The Department of Juvenile Services (DJS) provided supervision, placement, and offense-related data. The Department of Human Resources (DHR) compiled data regarding child welfare placements and investigations.

[2] Statewide implementation of FFT began in FY09; however, use of the data collection measure did not begin until FY10. This measure was developed by the EBP research and evaluation team which was formerly housed at the Innovations Institute.

[3] Note that the Maryland Department of Health and Mental Hygiene provided data on the interactions of the public mental health system; however, these data require additional validation analyses before reporting.

Utilization

Why do we care about utilization of EBPs?

Utilization data provide information about the youth referred and served by EBPs, as well as details of the admission process. Utilization data are important because they inform stakeholders of which populations are accessing services and which populations are not able to benefit from services. Utilization data also highlight parts of the admission process that are working smoothly, and parts that are in need of improvement. For FFT, the utilization data collected include date of referral, date of acceptance, date of rejection, date of assignment to an FFT therapist, date of first visit, and date of discharge. These dates are used to calculate the length of time a youth and his or her family are waiting at each stage of the admissions process and their total FFT length of stay. Reasons for why some youth are not accepted, waitlisted, or discharged are also collected. In combination with demographic information gathered of all youth referred to FFT, these data provide a picture of the "who, when, and why" of FFT service delivery in Maryland.

Outcomes

Why do we care about outcomes in EBPs?

Implementing an EBP effectively in the community is an ongoing, planned process, with specific steps that should lead to positive outcomes or positive direct effects of a program for the population served (Chinman, Imm, & Wandersman, 2004). Good outcomes are not based on the mere availability and utilization of evidence-based practices; they are critically dependent on how well therapists deliver the practices and the "fit" with the population being served. In order to understand whether an EBP achieves the desired level of change, it is critical to identify, carefully define, and evaluate the outcomes of that EBP.

What are the outcomes of interest for FFT?

FFT focuses on individual, family, and extra-familial risk and protective factors that impact youth behavior such as delinquency. 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 (Alexander & Parsons, 1973).

Program outcomes at discharge

Upon discharge from FFT, each case is evaluated to determine whether or not the family completed treatment; what the reason was for not completing treatment (if applicable); changes in youth and family functioning; youths' self-reported feelings about their social roles, as well as physical, behavioral, and emotional wellness pre- and post-treatment; parents' perception of their child's distress pre- and post-treatment; therapist's perceived change in family risk and protective factors post-intervention[4], and the youth's status in three areas of primary interest to stakeholders (i.e., ultimate outcomes).

[4] Future reports will examine youth, parent, and therapist perceptions and ratings of behavior change during FFT.

Ultimate outcomes provide basic, but critical, information about how the youth is functioning in the community at the time of discharge, and are significant indicators for the purposes of the statewide EBP implementation effort. The ultimate outcomes measured at discharge include whether the youth was living at home, was in school or working, and had any new arrests. Individual youth data are aggregated to compute the percentages of youth within jurisdictions or across the state who achieve these ultimate outcomes.

Program outcomes post-discharge

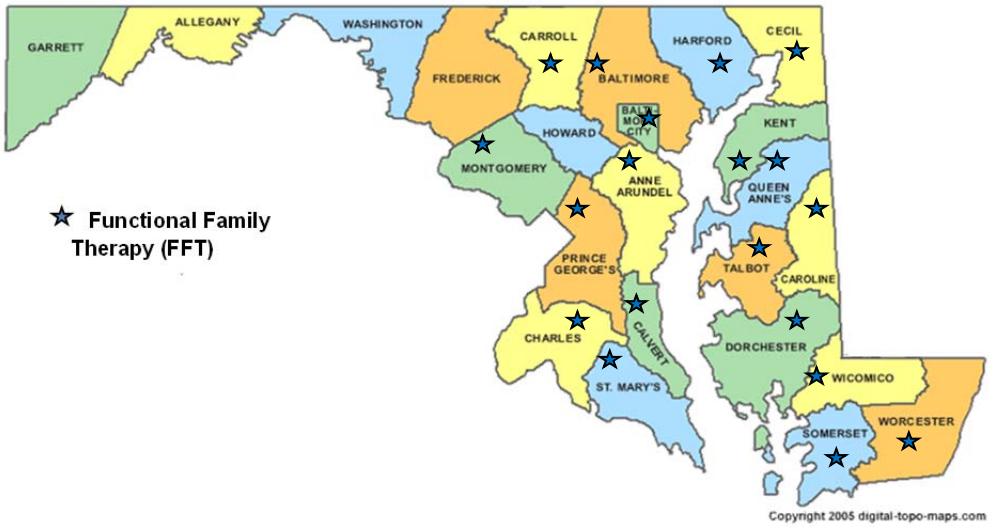
Based on input from Maryland's EBP Implementation Committee, which includes representatives from all State child-serving Agencies, The Institute collects data on specific outcomes from State Agency databases. These data will be used to determine the long-term impact of prioritized EBPs such as FFT. Specifically, the state is interested in measuring outcomes in the following areas:

- Youth residential and community stability;
- Youth and family functioning;
- Youth recidivism and rearrest;
- Youth school attendance and performance;
- Youth mental health functioning; and
- Youth safety.

Data reflecting these outcomes are expected to be collected at the start of services, at discharge, and one year *after* discharge. Currently, The Institute has data related to youth recidivism and rearrest, as well as child welfare investigations and placements, which are detailed in the Outcomes section of this report.

Functional Family Therapy in Maryland

Figure 1. Map of FFT in Maryland by Jurisdiction, FY11



Where was FFT Offered in Maryland?

During FY11, FFT was offered in 19 jurisdictions[5] in Maryland; only the Western Region of the state did not have FFT. Four providers—Baltimore County Bureau of Behavioral Health, Center for Children, Progressive Life Center, Inc., and VisionQuest—administered FFT for an estimated annual capacity of 1037 youth[6]. FFT was funded by DJS, DHR, the Children's Cabinet Interagency Fund (CCIF), and Medicaid; funding sources varied by jurisdiction (see Table 1).

Table 1. FFT in Maryland, FY11

Region(DJS)	Jurisdiction(s) Served	Provider	Funding Source	# Funded Daily Slots*
Baltimore	Baltimore City	VisionQuest	DJS	65
Central	Baltimore	Baltimore County Bureau of Behavioral Health	CCIF	--
			DHR	--
		VisionQuest	DJS	3
	Carroll, Harford	VisionQuest	DJS	9
Eastern Shore	Cecil , Caroline, Dorchester, Kent, Queen Anne, Somerset, Talbot, Wicomico, Worcester	VisionQuest	DJS	18
Metro	Montgomery, Prince George's	Progressive Life Center, Inc.	CCIF	--
		VisionQuest	DJS	79
Southern	Anne Arundel, Calvert, Charles, St. Mary's	Center for Children	CCIF	--
			DJS	93
			Medicaid	--

* The estimates provided represent the number of **slots funded by DJS as of June 30, 2011**. Note that other agency estimates will be available in FY12. Also, the number of active slots may vary by region during the fiscal year due to reallocation and other factors.

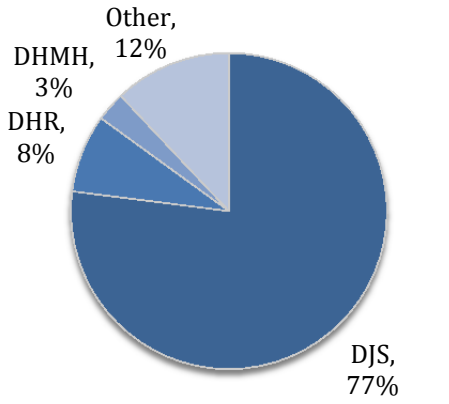
[5] Jurisdictions in Maryland refer to all Counties and Baltimore City.
[6] This figure is only based on the number of DJS-funded slots for FY11.

How was FFT Utilized in Maryland in FY11?

Who was referred to FFT?

The number of youth referred to FFT increased from 487 in FY10 to 1,138 youth in FY11, an increase of 133% while the State was expanding FFT across Maryland. The majority of these referrals were made by DJS (77%), followed by DHR (8%) and the Department of Health and Mental Hygiene (DHMH; 3%). Twelve percent of referrals came from other sources, which primarily included schools and self-referrals. (Refer to the Appendices for program and jurisdiction-level distributions of all descriptive statistics).

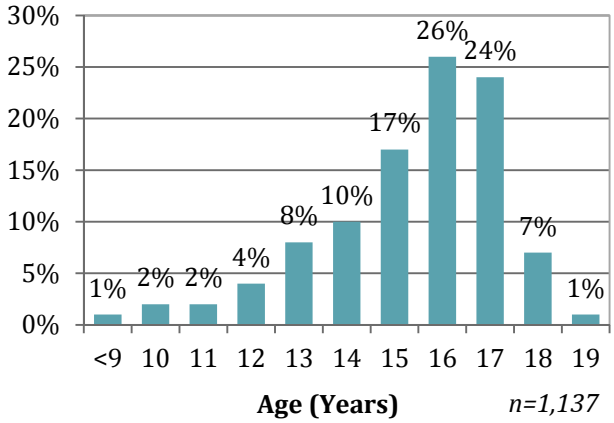
Figure 2. Referral Sources for Youth Referred to FFT, FY11



n=1,138

Half of the youth referred to FFT were 16 or 17 years old. Sixty-seven percent of youth referred were African American/Black—only a small share was Hispanic/Latino (3%) or another minority race/ethnicity (3%). Further, 73% of these youth were male. Note that, to the extent that DJS is the primary referral source for this program, the percentage of female referrals to FFT (27%) is consistent with the percentage of annual referrals to DJS (27% in FY10).

Figure 3. Ages of Youth Referred to FFT, FY11



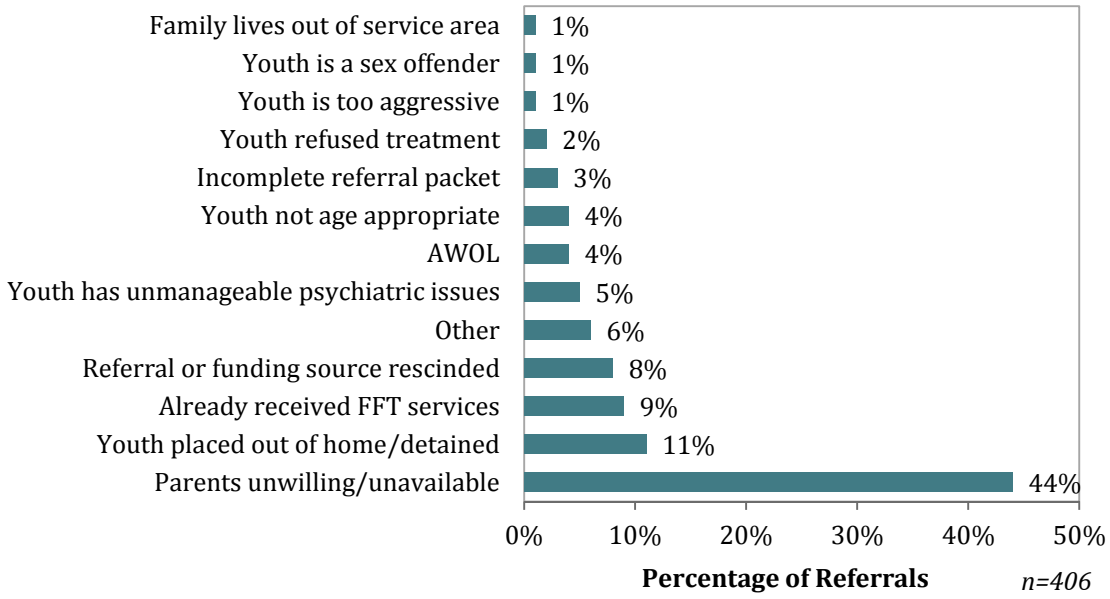
n=1,137

Table 2. Demographic Characteristics of Youth, FY11

		Youth Referred*	Started Services	Did Not Start Services
	Total Number of Youth	1,138	699	414
Gender	Male	73%	71%	74%
	Female	27%	29%	26%
Race/Eth.	African American/Black	67%	67%	68%
	Caucasian/White	27%	27%	26%
	Hispanic/Latino	3%	3%	3%
	Other	3%	3%	3%
	Average Age (s.d.)	15.3 (1.9)	15.5 (1.8)	15.1 (2.2)

**Due to pending admissions at the end of the year, the number of youth who started services and those who did not start services will not total the number of youth referred.*

Figure 4. Reasons Youth did not start FFT, FY11

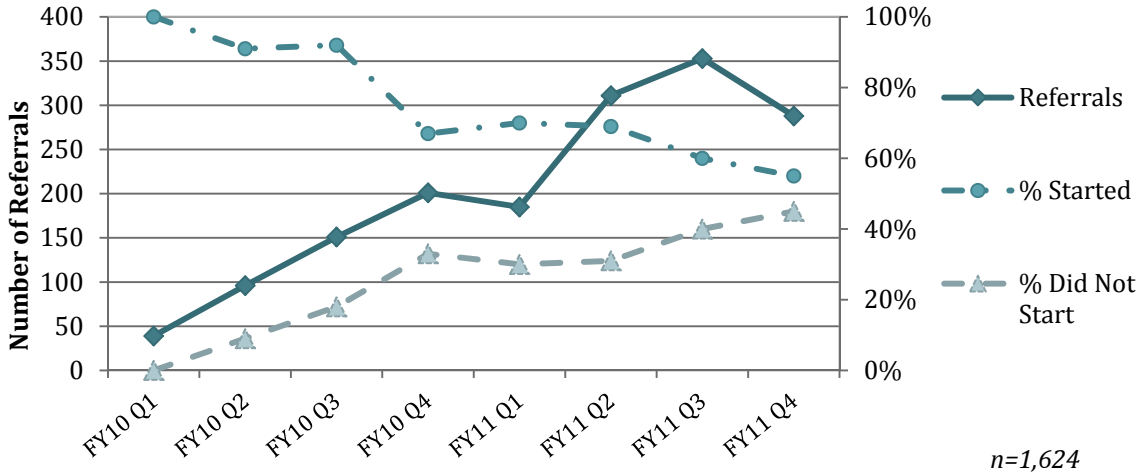


Who did not start FFT and why?

Of the 1,138 youth who were referred to FFT in FY11, 414 (36%) did not start services. The demographic characteristics of these youth were not statistically different from those who were referred. The most frequent reason for not starting services was *parents unwilling/unavailable* (44%); the next most frequently reported reasons included *youth placed out of home/detained*[7] (11%), *youth already received FFT* (9%), and *referral or funding source rescinded* (8%).

As referrals to FFT steadily increased during FY10 and FY11, the percentage of youth who did not start services also increased (see Figure 5). The 4th quarter of FY11 had the highest percentage of youth who did not start services (45%), with *parents unwilling/unavailable* (47%) being the most common reason provided that quarter, followed by *youth placed out of home/detained* (15%).

Figure 5. Number of FFT Referrals, Percent of Youth Who Started Services, and Percent that Did Not Start Services by Quarter, FY10 & FY11



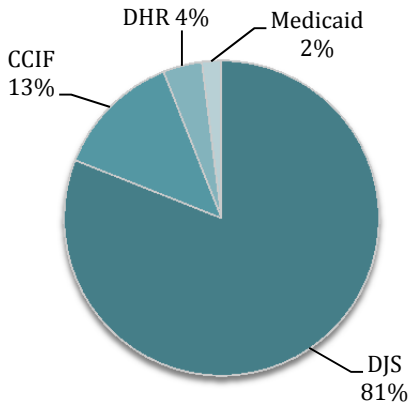
[7] In this case the youth was placed out of home or detained prior to the start of services.

Who was served by FFT?

The number of youth served by FFT increased from 370 in FY10 to 866 in FY11—a 134% increase in the youth served in Maryland in one year. (Note that the *number of youth served* includes admissions from FY11 as well as youth who were admitted from the previous fiscal year and still receiving services in FY11.)

The majority of youth served by FFT were funded by DJS (81%), followed by CCIF (13%), DHR (4%), and Medicaid (2%).

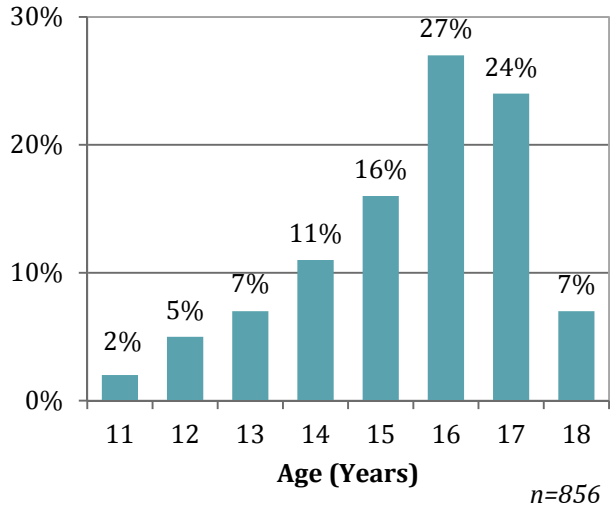
Figure 6. Funding Sources for Youth Served by FFT, FY11



n= 866

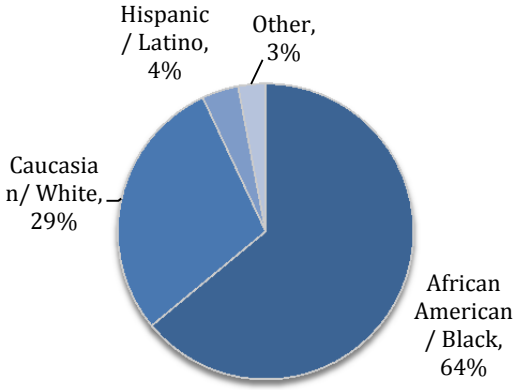
The median age of youth served by FFT was 16 years old, and youth ranged from 11 to 18 years old. The majority of youth were male (72%) and African American/Black (64%). Once again, note that even though the majority of youth served were males, the percentage of females served (28%) is consistent with the percentage of girls referred to DJS (27% in FY10)—the primary referral and funding source for FFT. The percentage of African American/Black youth served is also consistent with the percentage of African American/Black youth who are referred to DJS (60% in FY10).

Figure 7. Ages of Youth Served by FFT, FY11



n=856

Figure 8. Race/Ethnicity of Youth Served by FFT, FY11



n=866

Additional information about youth served

The Institute obtained additional data from DJS and DHR in order to better illustrate youth who received FFT during FY11. These data were linked with the EBP service data to describe prior and current involvement with these State Agencies.

Overall, 83% of youth served by FFT had at least one prior referral to DJS, and these youth tended to have considerable delinquency histories. On average, youth were 13.7 years old at the time of their first referral to DJS, and they had an average of 5 prior DJS referrals. Further, it was made evident by referral and funding data that most of the youth served were involved with DJS, but it is not obvious how these youth are involved with the system. Of the approximately 693 DJS-involved youth served by FFT during FY11, 61% were under probation supervision at the time of admission, 30% were under aftercare supervision (i.e., committed to DJS), and 9% were under another form of supervision (e.g., pre-court, administrative).[8] Of youth under probation or aftercare supervision, 9% were involved in DJS's Violence Prevention Initiative (VPI) at the time of admission to FFT.

The additional data obtained from DHR show that, of the 647 youth who received FFT and discharged in FY11[9], 66 (10%) had a history of involvement in the child welfare system. Either before starting or during the course of FFT treatment, 8 youth (1%) had been placed out-of-home, 31 (5%) had been placed in-home[10], and 1 youth (<1%) had received an [unsubstantiated] investigation for sexual abuse. There were 31 youth (5%) otherwise known to DHR that had never been placed or investigated.

Of Maryland youth served by FFT in FY11:

- ***83% had a history of involvement in the juvenile justice system***
- ***10% had a history of involvement in the child welfare system***

[8] In some DJS-funded cases, FFT was used as a step-down program for youth returning from residential placements. Between FY10 and FY11, only 8 youth had been released from an out-of-home placement within 30 days of admission to FFT.

[9] The data provided by DHR only included cases that were discharged on or before 6/30/2011. Hence, any youth who received FFT in FY11 and did not discharge by 6/30/2011 are not reflected in this section.

[10] The youth received child welfare services while residing in the home of the caregiver.

What do Youth Look Like upon Discharge from FFT?

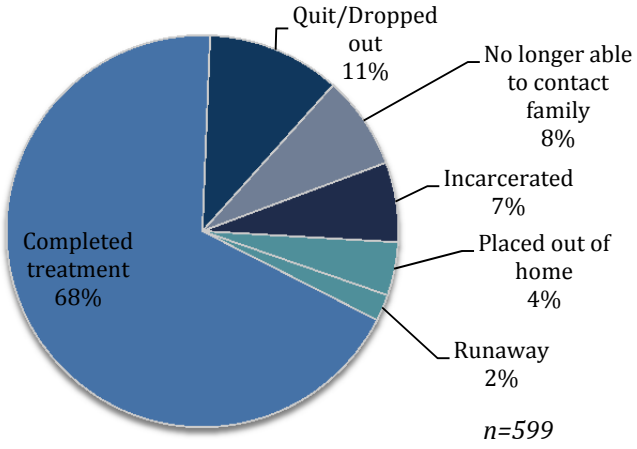
Upon discharge from FFT, each case is evaluated to determine whether or not the youth and family completed treatment, and the reason for not completing treatment, as well as how the youth is doing in three areas of primary interest to stakeholders (i.e., ultimate outcomes) at discharge. Most pertinent for the purposes of this report, and for the statewide EBP expansion effort, is the focus on *ultimate outcomes*, which provide basic, but critical, information about how the youth is functioning at discharge.

How many youth were discharged from FFT and why were they discharged?

Youth are discharged from FFT for reasons *within therapists' control* or for reasons *not in therapists' control*. Reasons for discharge within therapist control include: youth completed treatment, the youth and family quit/dropped out after contact, youth was incarcerated, therapist no longer able to contact youth/family, youth ran away, and youth was placed out of home. Discharge reasons that therapists cannot control include: youth moved, youth discharged for administrative reasons (e.g., youth did not meet FFT criteria, were incarcerated for pre-referral reasons, or funding was terminated), and youth was referred to other services. Of the 657 cases discharged in FY11, less than 10% of cases were discharged for reasons outside of therapist control.[11] *Note that these cases will not be included in subsequent analyses.*

Overall, 599 youth were discharged from FFT for reasons within therapist control in FY11. The average length of stay (ALOS) in treatment was 118 days—close to the national purveyor's target of 120 days. The majority of youth completed treatment (68%, n=410). Of those who did not complete FFT, the most common reasons were that the *youth/family quit or dropped out* (11%) and the *therapist was no longer able to contact the family* (8%). Seven percent of all discharged youth were *placed or incarcerated <u>during</u> treatment*, and an additional 4% were *placed out of home* (e.g., in a Substance Abuse Program, Group Home, or Therapeutic Group Home). The ALOS was significantly longer for youth who completed the program (134 days), as compared with those who did not complete (84 days).

Figure 9. Discharge Reasons for Youth Discharged from FFT, FY11



[11] Of those discharged outside of therapist control, 4% were discharged for administrative reasons, 3% moved, and 3% had been referred for other services.

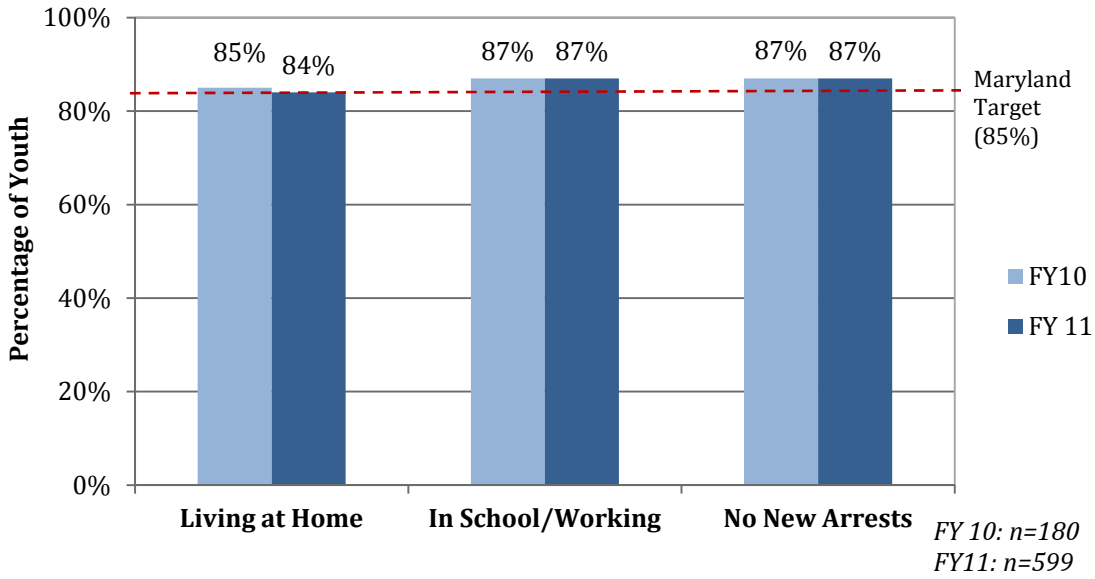
FFT ultimate outcomes at discharge

As mentioned earlier, the ultimate outcomes are among the most important indicators for FFT's success with youth and are key measures to review when evaluating statewide implementation. Even though most youth complete FFT, it does not mean that the program will be effective for every youth. Three measures of success constitute the ultimate outcomes—whether the youth was living at home at discharge, whether the youth was in school and/or working at discharge, and whether the youth had been arrested for a new offense since treatment had started. Other indicators of success include related post-discharge outcomes, which are discussed in the next section.

Figure 11 shows the Statewide ultimate outcomes for the 180 youth discharged from FFT in FY10 and the 599 youth discharged in FY11. Overall, these youth achieved, or almost achieved, the Maryland FFT target[12] of 85% in all three outcome categories both fiscal years. Further, youth who completed FFT treatment were significantly more likely to be living at home, in school, and not have a new arrest compared to youth who did not complete treatment. Of the 410 youth who completed treatment in FY11, 97% were living at home, 93% were in school and/or working, and 95% had no new arrests upon discharge. Moreover, 87% of the youth who completed FFT treatment had positive results in all three of the ultimate outcomes. These outcomes are very encouraging taken as a whole.

Readers should note that the ultimate outcomes are reported by FFT therapists, who may not be aware of all youth contacts with law enforcement or the justice system. Further, not all contacts with the system may be the result of an arrest—youth may also be referred to DJS from other sources (e.g., school). According to DJS data, 18% of youth had been referred to DJS while receiving FFT in FY11—as opposed to the reported 5% who had new arrests upon discharge (see above).

Figure 10. Ultimate Outcomes for Youth Discharged from FFT, FY 10 and FY11



[12] This target was established with FFT purveyors, and considered an appropriate mark while FFT is being brought to scale in Maryland.

How do youth fare after discharge from FFT?

Juvenile and criminal justice system involvement. Research has demonstrated that participation in FFT is associated with a reduced risk for delinquency and criminal behavior over time. In order to assess longitudinal outcomes in Maryland, the Institute provided DJS with the name, gender, race/ethnicity, and date of birth of *all* youth who were discharged from FFT in FY10, in order to identify matches in DJS's automated case management system (ASSIST). DJS also requested and retrieved related records from the adult criminal justice system since many of these youth were older (e.g., 17 years old) and any new offenses may fall under adult jurisdiction. Following DJS's recidivism criteria, subsequent involvement with DJS and the adult system during the follow-up period were combined and categorized as arrested, convicted, and incarcerated (see insert for definitions of these terms).

Juvenile & Criminal Justice Involvement/Recidivism Measures

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

Arrest refers to any subsequent contact with either the juvenile or adult justice system.

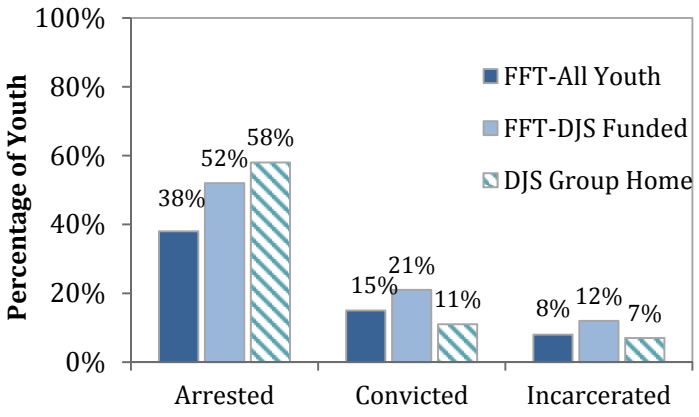
Conviction refers to any youth who has a judiciary hearing and is adjudicated delinquent, or is arrested and has a criminal hearing in the adult system and is found guilty.

Incarceration refers to any youth who is committed to DJS custody for placement, or is arrested, convicted, and incarcerated in the adult system.

In FY10, 180 youth were discharged from FFT. Of those 180, 10 (6%) had been placed in a secure DJS facility (i.e., detention, staff-secure residential, and hardware-secure residential) at the time of FFT discharge. Recidivism rates for these youth are not reported due to insufficient follow-up data. Of the 170 youth who remained in the community, 38% were arrested, with 15% having a charge that resulted in a conviction, and 8% ultimately being incarcerated in the 12 months following discharge.[13] Youth who completed FFT (n = 124) had similar rates: 40% were arrested, 16% convicted, and 8% incarcerated within one year.

In order to evaluate how well FFT youth fared in comparison to similar youth in other treatments or placements, DJS identified a sample of youth who were demographically similar to those in FFT but discharged from either group homes or therapeutic group homes in FY10. In Maryland, FFT is used as a diversion option for those youth who are at risk of placement in group homes, rendering this a suitable comparison group.

Figure 14. 12-Month Recidivism Rates for Youth Discharged from FFT and DJS Group Homes, FY10



FFT-All n=170
FFT-DJS Funded n=120
DJS Group Home n=314

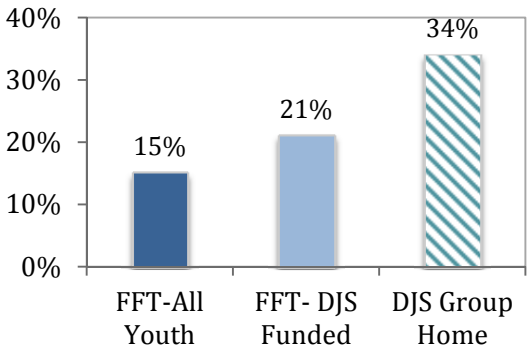
The group home sample of youth was primarily male (83%) and African American (75%), with an

[13] Females were significantly less likely to be arrested, convicted, and incarcerated 12 months post-treatment.

average age of 16 years old. The average length of stay in group homes was 7 months. Of the 401 discharged youth, 22% (n=87) were placed in a secure DJS facility upon release. Of the 314 youth who remained in the community, 58% were arrested, 11% were convicted, and 7% were incarcerated in the year following release from the group home. Compared with FFT youth who were also under DJS supervision (i.e., DJS funded), youth released from group homes had slightly higher rates of arrest (52% vs. 58%), but slightly lower rates of conviction (21% vs. 11%) and incarceration (12% vs. 7%). Caution should be exercised when interpreting these estimates though, since this analysis did not account for all potential differences between FFT and group youth.

New residential placement with Juvenile Services. Youth involved with DJS do not need to commit a new offense and 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 incarceration (shown above). Of the 170 youth who were discharged from FFT to the community in FY10, 15% were admitted to a residential facility[14] by DJS during the 12 months following discharge. The most frequent types of placements included Youth Centers, group homes, secure facilities, and residential treatment programs. Compared with the sample of DJS youth who were released from group homes in FY10, significantly fewer FFT youth under DJS supervision (i.e., DJS funded) experienced a subsequent residential placement (34% vs. 21%). Note that these percentages do not include youth who were detained or residing in a facility at discharge from FFT or group homes (see above).

Figure 15. New DJS Residential Placement within 12 Months Post-Discharge of FFT and DJS Group Homes, FY10



FFT-All n=170
FFT-DJS Funded n=120
Group Home n=314

Also note that the availability of FFT was substantially increased across Maryland in FY10, and this program scale-up generated significant implementation challenges (e.g., achieving fully staffed programs, obtaining appropriate referrals, etc.). It is likely that youth outcomes were impacted by these challenges, and it is expected that outcomes will improve as program implementation improves, over time.

Child welfare system involvement. Similar to DJS, The Institute provided DHR with the names, dates of birth, and other demographic variables of all youth who were discharged prior to the last day of FY10. DHR matched these youth in their Children's Electronic Social Services Information Exchange (CHESSIE) to retrieve information about contact with DHR post-FFT discharge. As per DHR data, 8 (4%) of the 180 youth discharged in FY10 had a history of involvement in the child welfare system, all of which occurred either prior to or during FFT treatment. No youth discharged in FY10 have since been placed or investigated by DHR.

[14] In this case, DJS residential placements include places such as Youth Centers, group homes, residential treatment facilities, treatment foster care, etc. It does not include detention.

Significant Findings

Who did FFT serve in Maryland and how were services utilized?

- In FY11, FFT was provided in 18 jurisdictions throughout the State.
    - FFT increased Maryland's capacity to provide community-based services for at risk and delinquent youth. Estimated annual capacity in Maryland for FY11 was **1,037 youth**.
- **1,138 youth were referred** to FFT; 36% of these referrals were not accepted.
    - The most common reason for not accepting a referral was that the parent(s) was unwilling or unavailable for participation (44% of all non-acceptances).
- **866 youth were served** by FFT in FY11— a 134% increase from FY10.
- The median age of youth served was **16 years old**; the majority of youth served were **African-American (64%)** and **male (73%)**.
- The majority of these youth were involved with DJS upon admission to FFT, and these youth had considerable delinquency histories—on average, these youth had 5 prior referrals to DJS. Very few youth had prior involvement with the child welfare system.
- **The majority of youth completed FFT** (68% of those discharged within therapist control).
    - Reasons for non-completion in FY11 include: youth family quit or dropped out (**11%**), FFT therapist no longer able to contact family (**8%**), youth was incarcerated (**7%**), youth placed out of home (**4%**), and youth ran away (**2%**).

Did FFT affect youth outcomes in Maryland as expected?

- Among youth who were discharged from FFT in FY11, **84%** were living at home, **87%** were in school or working, and **87%** had no new arrests as of discharge.
    - Of FFT completers, **97%** were living at home, **93%** were in school or working, and **95%** had no new arrests as of discharge.
- **62%** of youth discharged from FFT did not recidivate in the year following discharge (were not referred to DJS or arrested), and **92%** had no new commitments to DJS or were incarcerated in the adult system. Further, **85%** of these youth did not have a new residential placement with DJS in that year, and none of the youth discharged from FFT had any subsequent involvement in the child welfare system.
- Compared with a sample of demographically similar DJS youth who were discharged from group homes and therapeutic group homes in FY10, FFT youth under DJS supervision were less likely to be arrested, but more likely to be convicted and incarcerated.

Implications

The aggregated FFT data provided in Maryland for FY11 indicate that a diverse population of youth and families received FFT. The majority of youth had positive outcomes at the time of discharge from FFT, and only a small percentage of youth who received services were ultimately committed to DJS because of a new referral or arrest after discharge. These outcomes are expected to get better as FFT implementation is improved over the coming years.

Future Directions and Recommendations

1. State and local stakeholders should support FFT providers in conducting informational briefings with the judiciary system.

2. Referral agencies and FFT providers should continue frequent and consistent communication to track and maintain referral flow based on current openings and upcoming discharges. Given the high rates of youth not starting services due to parental unwillingness or availability, greater effort should be expended to educate parents on the goals of the program, encourage participation, and work with parents to ensure that the program suits their circumstances.

3. The EBP Advisory Committee subgroup on Family Engagement should continue to develop small grants to pilot a peer support model designed specifically for EBP implementation.

4. FFT providers should continue to educate referral sources and judicial leadership about FFT goals and strategies.

5. Stakeholders should support regular communication between Contract Management System staff and FFT Therapists.

6. FFT vendors should continue working closely with FFT national consultants to systematically carry out improved engagement strategies, fidelity to the model, and increased session frequency to ensure higher completion rates, and ultimately better outcomes for youth and families.

7. The Institute for Innovation and Implementation should continue to facilitate discussions between FFT national consultants, FFT providers, and referral agencies to improve implementation of FFT in Maryland.

8. The Institute for Innovation and Implementation should continue to work with DJS to identify a comparable youth sample to youth who receive FFT, matched on additional factors (including those individual and family factors that may place youth at increased risk of delinquency), to better understand how FFT compares to other treatment options available in Maryland for delinquent youth at risk of out-of-home placement.

General EBP Implementation and Evaluation

Presented below is a brief outline of the necessary phases of program implementation, especially useful for EBPs. These phases are based on work developed by the National Implementation Research Network and published in Implementation Research: A Synthesis of the literature (Fixsen et al., 2005; found at http://www.fpg.unc.edu/~nirn). Careful consideration and adoption of these phases is critical to the successful implementation of EBPs, and improves the likelihood that the EBPs will achieve their desired outcomes. In addition, utilization and EBP model fidelity are highly dependent on how well these phases of implementation are established and at what phase a program is on this continuum.

PHASES OF IMPLEMENTATION

1. **Exploration and Adoption** – When a determination is made regarding whether a specific EBP is a match for the community. An assessment of the community's needs, available resources, and readiness to implement a new practice is completed, and research findings are used to determine the most appropriate EBP to meet the community's needs. Assessment questions include: What are the needs of the community? How ready is the community for change? Who are the key stakeholders? What are the community resources to support the EBP? This phase may take approximately 2-3 months to complete.
2. **Program Installation** – When several tasks are completed to ensure that the community and organization implementing the EBP have the necessary infrastructure and support to implement the EBP model with fidelity, Tasks may include ensuring availability of funding streams, creating referral mechanisms, ensuring staffing resources, ensuring staff qualifications, and communicating expectations around reporting and outcomes. This phase may take approximately 2-3 months to complete.
3. **Initial Implementation** – The process of adopting the new EBP is ongoing, and the community and organization is supported via additional education, practice, and technical assistance. This phase may take approximately 1-2 years to complete.
4. **Full Operation** – Occurs when learning the EBP is fully integrated into existing community and organization practices, policies, and procedures, and the EBP is used with proficiency and high fidelity. This is an ongoing phase that occurs *at least* 1-2 years.
5. **Innovation** – Occurs when minor changes are made to the EBP that might facilitate implementation in the community and organization, and enhance the standard EBP model; these changes occur *after* the EBP has become fully operational and is done with consistent high fidelity.
6. **Sustainability** – When the EBP has become fully implemented and the goal is to determine ways to ensure its long-term and continued effectiveness in the community. Phases 5 and 6 are ongoing processes that occur *at least* over a 2-4 year period, after full operation has been successfully achieved.

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