FUNCTIONAL FAMILY THERAPY IN MARYLAND: FY 2014 IMPLEMENTATION REPORT

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

MAY 2015

Suggested citation: Farrell, J., Betsinger, S., Chen, D., Lowther, J., Dutrow, D., Acuna, R., & Zabel, M. (2015). Functional Family Therapy in Maryland: FY2014 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 providing empirically-supported community-based services that address key youth outcomes and reducing costly out-of-home placements. Since 2007, The Institute for Innovation & Implementation has supported FFT implementation in Maryland, providing technical assistance and data reporting to providers and stakeholders. The following report summarizes FFT utilization, fidelity, outcomes, and costs across the State for fiscal year (FY) 2014.

FY14 Data Highlights

Utilization

- FFT was available in 20 jurisdictions throughout Maryland. Based on FY14 funding capacity, Maryland could serve an estimated 930 youths in FFT annually. The Statewide utilization of FFT was 69%, and utilization based on actual capacity (available slots) was 79%.
- 1,041 youths were referred to FFT in FY14. The majority of referrals were provided by the Department of Juvenile Services (DJS; 75%). Of those youth referred, 67% started treatment, which was a slight decrease from FY13. Issues with obtaining youth/family consent for treatment and difficulty contacting the family were the primary reasons youth did not start FFT.
- The majority of youth who started FFT were African American/Black (59%) and male (72%), and the average age was 15.9 years old. Most youth were involved with DJS upon starting FFT, and these youth had considerable delinquency histories—on average, youth had five prior complaints filed with DJS. In addition, 49% of youth had prior involvement with the child welfare system.

Fidelity

- The Average Fidelity Score continued to exceed the national FFT target of 3.00 since FY11, with an average therapist score of 4.05 this fiscal year. The Average Dissemination Adherence Score of 4.50 also exceed the target score (4.00).

Outcomes

- 658 youths were discharged from FFT within the therapist's control in FY14, and **76%** of these youth had completed treatment, similar to the 78% completion rate from last year.
- Of youth who completed FFT in FY14, at the time of discharge: **98%** were living at home, **99%** were in school or working, and **94%** had no new arrests.
- Of youth who completed FFT in FY13, as of one year post-discharge: **55%** did <u>not</u> have a new DJS referral/arrest, **81%** had not been adjudicated delinquent/convicted, and **91%** had <u>not</u> been committed/incarcerated. Additionally, **87%** had <u>not</u> been placed into a committed residential placement with DJS.
- Only **7%** of youth who completed FFT in FY13 had any involvement with the child welfare system within one year.

Costs

- The average cost of service delivery for providing FFT in Maryland, including training, coaching, and implementation data monitoring in addition to provider costs, was $3,795 per youth.

Introduction

Purpose of this Report

Functional Family Therapy (FFT) is a widely-recognized evidence-based practice (EBP) that is 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 improving outcomes for youth and families and reducing the use of out-of-home placements.

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) 2014. 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 for 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.

FFT 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). Table 1 summarizes FFT's ratings on four nationally-recognized EBP registries. For additional information on FFT, please go to www.fftinc.com.

Table 1. FFT Ratings on National EBP Registries*

EBP Registry	FFT Rating(s)
Blueprints for Healthy Youth Development **www.blueprintsprograms.com**	Model Program
California Evidence-Based Clearinghouse for Child Welfare **www.cebc4cw.org**	2: Supported by Research Evidence (reviewed September 2013)
SAMHSA's National Registry of Evidence-Based Programs & Practices (NREPP) **www.nrepp.samhsa.gov**	Not Listed
Office of Justice Programs' CrimeSolutions.gov **www.CrimeSolutions.gov**	Effective Program

*Ratings as of November 2014.

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: Anna's Story*

Anna is a 15 year-old girl who was referred to FFT for help with emotional regulation issues. Anna's mother had been struggling with her own mental health issues, so Anna spent some time living elsewhere before finally returning to her mother. During the intake meeting, she was unable to maintain a calm demeanor, became incredibly escalated, and made several threats to family members. It became clear that Anna wanted more connection with her family members than they were able to give her, which led to several incidents.

To address these issues, the therapist introduced active listening and "I-statements" to increase acknowledgment and understanding between family members, as well as emotional regulation skills to be used when Anna was feeling upset. These skills included identifying coping skills as well as identifying supportive friends who Anna could reach out to if needed.

By the end of treatment, Anna was able to show her more playful side and was able to talk and laugh with her mother. Anna and her mother were able to use new communication skills to express themselves differently. Also, Anna was able to use coping skills she learned in sessions to try to prevent situations from escalating as they had in the past. At the time of discharge, Anna and her mother were able to spend time together, and Anna was even able to spend an extended length of time with her Grandmother, who was initially a major source of tension.

**The client's name has been changed.*

Assessing FFT Utilization and Outcomes

The data presented in this report are drawn primarily from youth-level data routinely collected by Maryland FFT providers. Additional data are provided by DJS, Department of Public Safety and Correctional Services (DPSCS), and 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 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 2). 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 2. 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
Post-Discharge 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 FY14. Where possible, data are presented and comparisons are drawn for previous fiscal years. Refer to Appendix 1 for FY14 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 FY14, 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 youths[3]; there were no changes in capacity from FY13. 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 3).

Figure 1. FFT Availability in Maryland, FY14

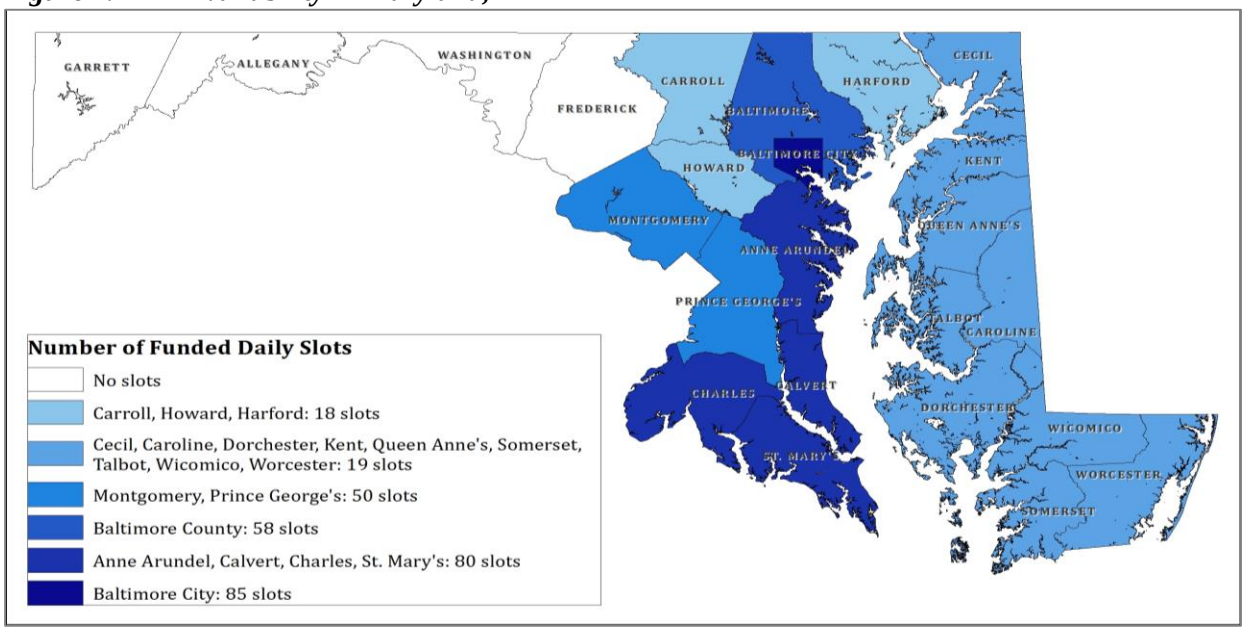


Table 3. FFT Service Provision & Funding Sources in Maryland, FY14

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.

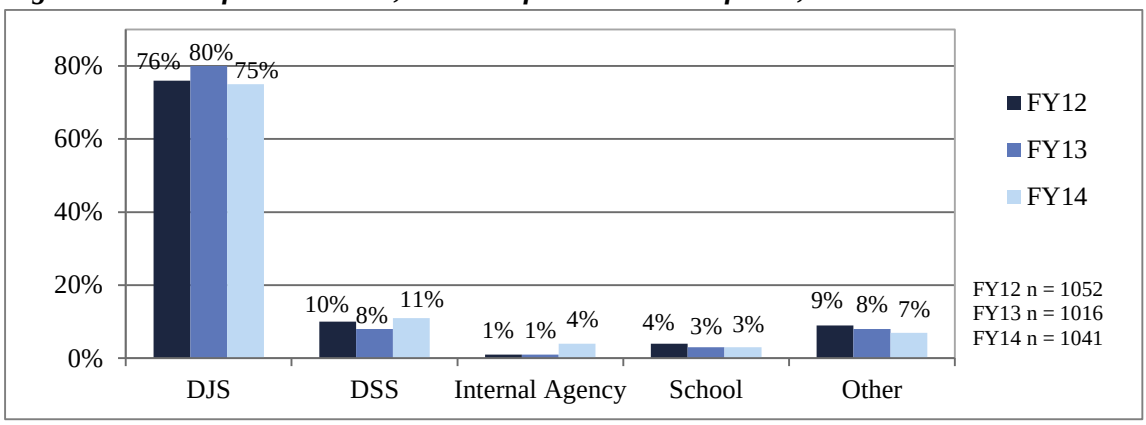
[3] The estimated annual capacity is based on the average number of slots funded by DJS, CCIF, and DSS during FY14 (n=310). It assumes that each youth will remain in FFT for an average length of stay of 120 days, and that three youths can be served in each slot during the course of the year.

Referrals to FFT

Referral Sources

In FY14, the majority of the 1,041 referrals were made by DJS (75%), followed by DSS (11%), the provider agency (4%), and schools (3%; Figure 2). Seven 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, Percent of Total Youth Referred, FY12-FY14



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 FY14, almost all referred youth met the age criteria for FFT. These youth tended to be older adolescents—65% were between the ages of 15 and 17 years old (Figure 3), and the average age was 15.7 years old. Sixty-three percent of referred youth were African American/Black, 27% Caucasian/White, 6% Hispanic/Latino, and 5% another race/ethnicity (Table 4). Further, 70% of these youth were male. Characteristics of youth referred to FFT have been fairly constant over the past few years.

Figure 3. Ages, Percent of Youth Referred to FFT, FY14

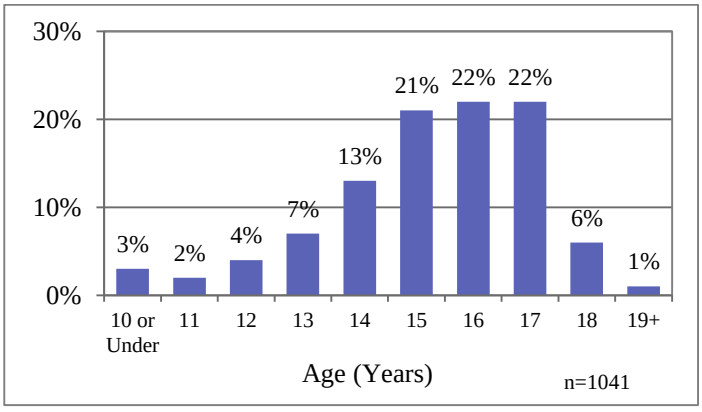


Table 4. Demographic Characteristics of Youth Referred to FFT, FY12-FY14

	FY12*	FY13**	FY14
Total Number of Youth	1,052	1,016	1,041
Male	72%	72%	70%
Female	28%	28%	30%
African American/Black	61%	65%	63%
Caucasian/White	29%	27%	27%
Hispanic/Latino	5%	4%	6%
Other	5%	4%	5%
Average Age (s.d.)	15.9 (1.9)	15.9 (1.9)	15.7 (1.9)

*Age was not reported for one youth who was referred in FY12.
**Race/ethnicity was not reported for one youth who was referred in FY13.

Referred Youth Who Did Not Start FFT

Not all youth referred to FFT start treatment (i.e., had a first visit, treatment consent is signed by the family). In some instances the FFT provider may determine that the youth and/or family are not eligible for FFT or the youth/family may be eligible but they choose not to start for another reason. For the past three fiscal years, two-thirds or more of referred youth started FFT (Figure 4). The majority of youth who did not start were eligible for FFT, including 208 youths in FY13 and 222 youths in FY14 (Figure 5).

Figure 4. Percent of Referred Youth Who Started FFT, FY12-FY14

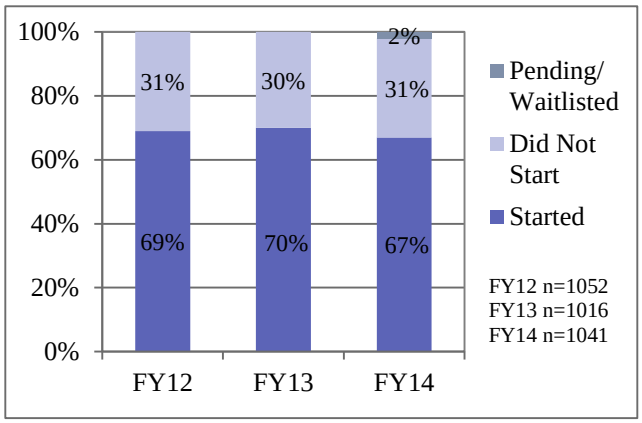


Figure 5. Number of Youth Who Did Not Start FFT by Eligibility, FY12-FY14

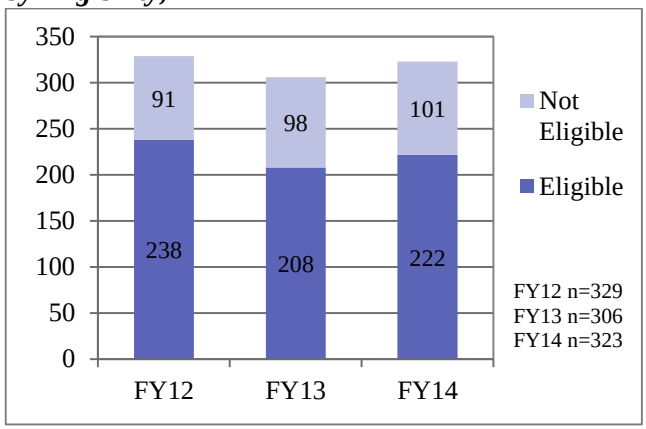


Figure 6 lists the reasons for not starting FFT that are indicated by the providers. These reasons are closely monitored over time as they offer important information about how to improve the referral process, including how to increase appropriate referrals and decrease barriers to treatment engagement. Ultimately, utilization is highly dependent on a sufficient flow of referrals for eligible youth and families who could benefit from FFT.

Figure 6. Reasons for Not Starting FFT

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

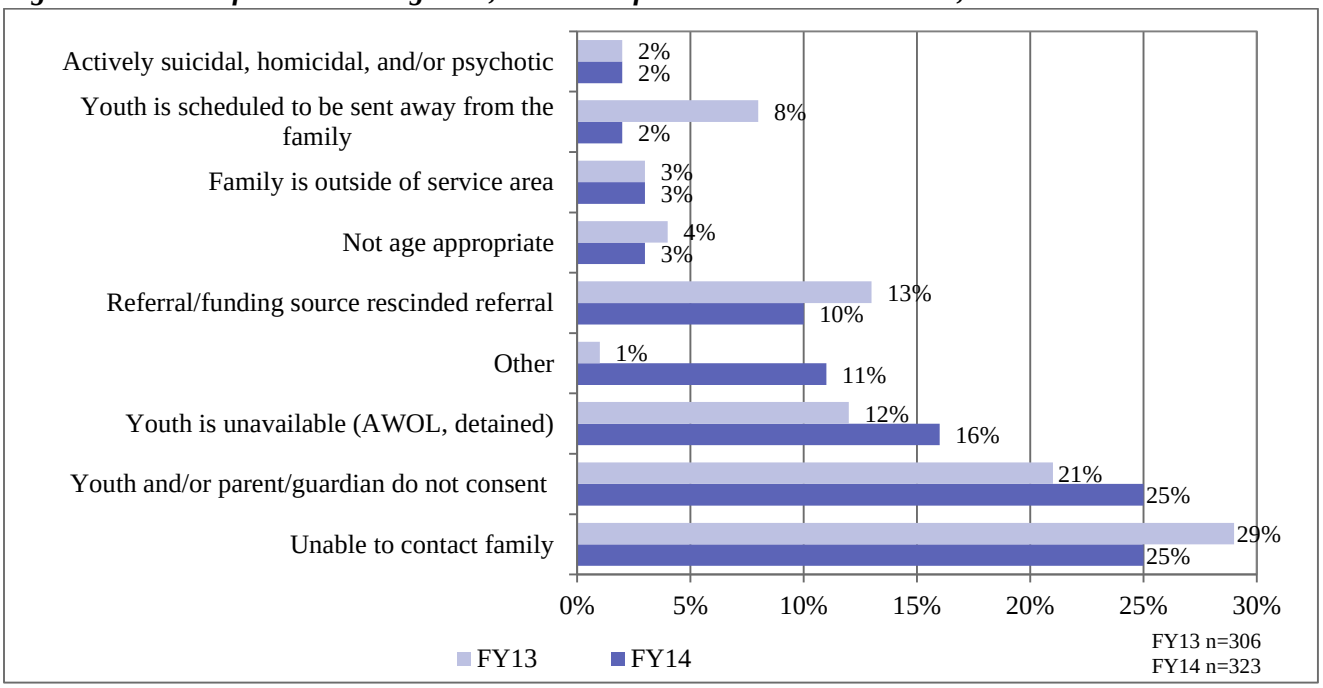
- *Age appropriateness;*
- *Youth has unmanageable medical issues;*
- *Suicidal, homicidal, or psychotic issues;*
- *Diagnosed with autism, pervasive developmental delay, mental retardation, or with an IQ less than 75;*
- *Diagnosed primarily as a sex offender;*
- *No psycho-social system/ no identifiable 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.*

Figure 7 shows the specific reasons that youth did not start FFT in FY13 and FY14. In both years, half of youth did not start treatment due to reasons related to youth and family unwillingness or unavailability. In FY14, *unable to contact family* and the *youth and/or parent/guardian do not consent* accounted for equal proportions (25%) of youth who did not start treatment.

Figure 7. Reasons for Not Starting FFT,* Percent of Youth Who Did Not Start, FY13-FY14



*In FY14, 1% or less of youth did not start FFT for each of the following reasons: youth diagnosed primarily as a sex offender; youth has unmanageable medical issues; youth diagnosed with Autism, pervasive developmental delay, mental retardation, or with an IQ less than 75; youth already completed a full course of FFT treatment; and youth has no psycho-social system/no identifiable caregiver.

Waitlisted Youth

In FY14, 576 (55%) youths were placed on the waitlist—up from 444 (42%) in FY12 and 383 (38%) in FY13. The characteristics of youth placed on the waitlist in FY14 were slightly different from those referred, with 66% male (compared with 70% of referred youth) and 58% identified as African American/Black (compared with 63% of referred youth). Consistent with the previous fiscal year, slightly less than one-third (30%) of youth who were placed on the waitlist did not ultimately start FFT (Figure 8; note some cases where still pending start outcomes at the close of the fiscal year).

Figure 8. Percent of Waitlisted Youth Who Started FFT, FY12-FY14

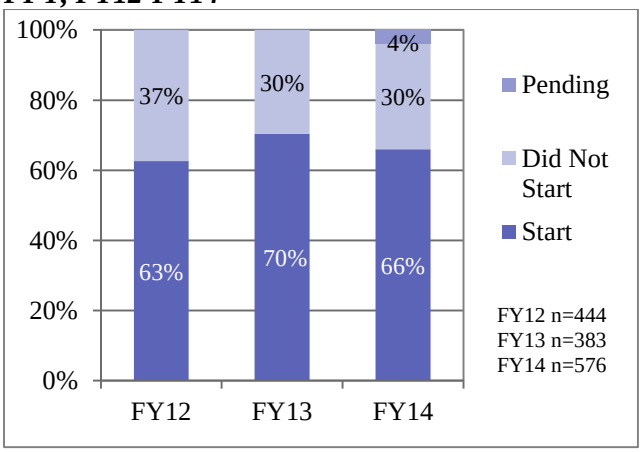
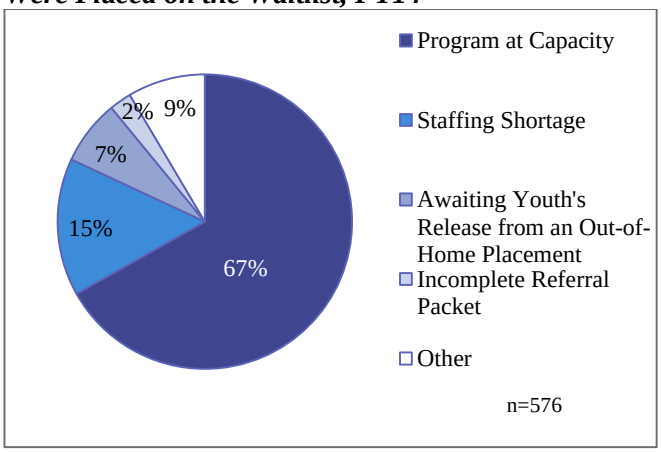


Figure 9. Waitlist Reasons, Percent of Youth Who Were Placed on the Waitlist, FY14



Youth can be placed on the waitlist even when the program is not fully utilized due to reductions in available therapists. Two-thirds (67%) of youth were placed on the waitlist in FY14 because the program was operating at capacity (Figure 9). An additional 15% were waitlisted due to staffing shortages, and 9% (n=49) were placed on

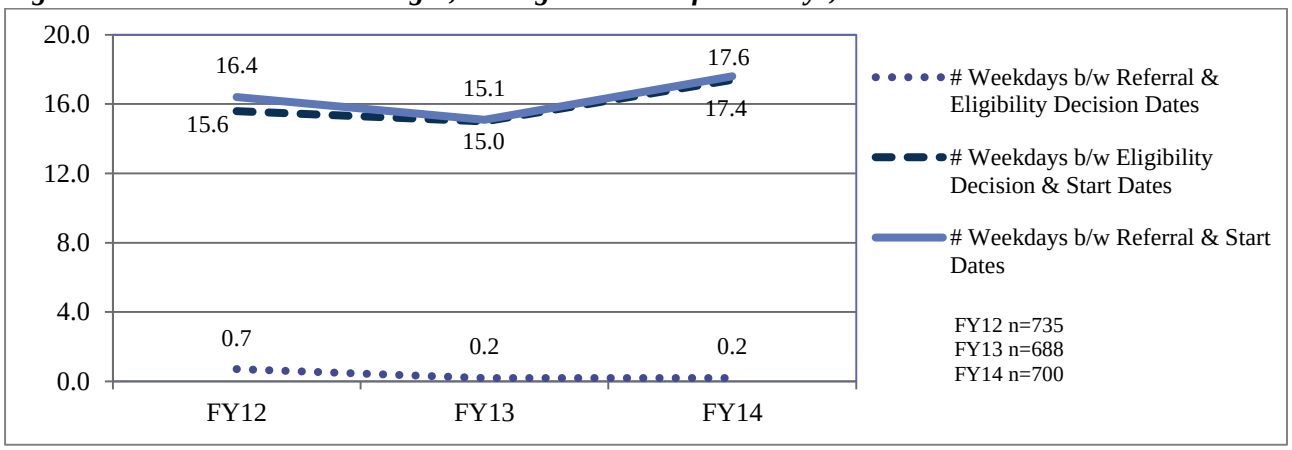
the waitlist for "other" reasons, including training a new therapist/therapist building caseload (n=22; 45%) and the need for a bilingual/Spanish-speaking therapist (n=8; 16%).[4]

Youth Who Started FFT

Global Admission Length (Initial Case Processing)

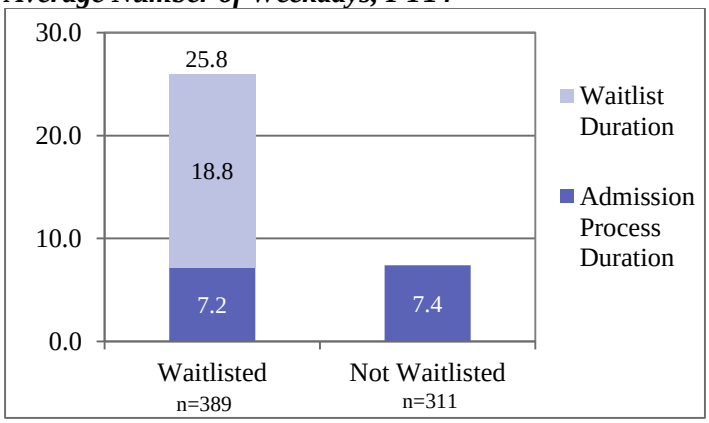
Once a youth is referred to FFT, it is critical that an eligibility decision is made in a timely manner and that treatment starts soon thereafter. FFT providers report referral, eligibility decision, and start dates, so this process can be closely monitored. The number of days between the referral and start dates is referred to as the *global admission length*. The average global admission length has increased slightly over the past three years (Figure 10). In FY14, providers generally made an eligibility decision within one weekday of receiving the referral, and youth typically started treatment within approximately three to four weeks (18 weekdays) of this decision.

Figure 10. Global Admission Length, Average Number of Weekdays, FY12-FY14*



Among the 700 youths who started FFT in FY14, 389 (56%) were temporarily placed on the waitlist. As shown in Figure 11, waitlisted youth took an average of 26 weekdays to enter treatment, while non-waitlisted youth took an average of seven weekdays.

Figure 11. Global Admission Length by Waitlist Status, Average Number of Weekdays, FY14



There were a number of statistical differences in the global admission length by subgroups of youth (see Table 5; only significant differences shown), as well as differences across agencies and jurisdictions (Appendix 1). Notably, youth whose participation in FFT was funded by CCIF had a significantly longer global admission length (35.2 days) than youth funded by other sources. Consistent with the previous discussion, those youth placed on the waitlist experienced a significant delay in the start of services compared to non-waitlisted youth.

[4] Waitlist reasons were not standardized until FY14; future reports will include comparisons across fiscal years.

Table 5. Statistically Significant Differences in Global Admission Length (GAL; weekdays)		
Factor	**Shorter GAL**	**Longer GAL**
Gender	Male (16.5)	Female (20.5)
Age at Admission	15 years and older (16.5)	Under 15 years old (21.0)
Prior DJS Complaints	Yes (15.3)	No (30.1)
Funding Source	DJS (14.9) DHR/DSS (20.6) Medicaid (16.7)	CCIF/LMB (35.2)
Waitlisted	No (7.4)	Yes (25.8)

Utilization

A total of 700 youths started FFT in FY14; this represents a slight increase from FY13 (n=689; Figure 12).

DJS has been the primary funding source for FFT for the past few years; accordingly, the majority of youth who started FFT in FY14 were funded by DJS (81%), followed by CCIF (12%), and DSS (5%; Figure 13). Just two percent of youth were funded through Medicaid.

Figure 12. Number of Youth Who Started FFT, FY12-FY14

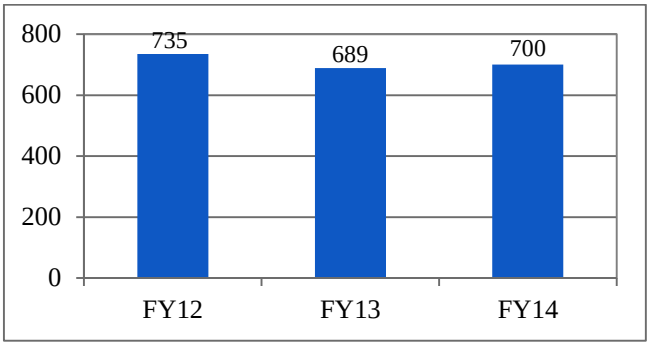
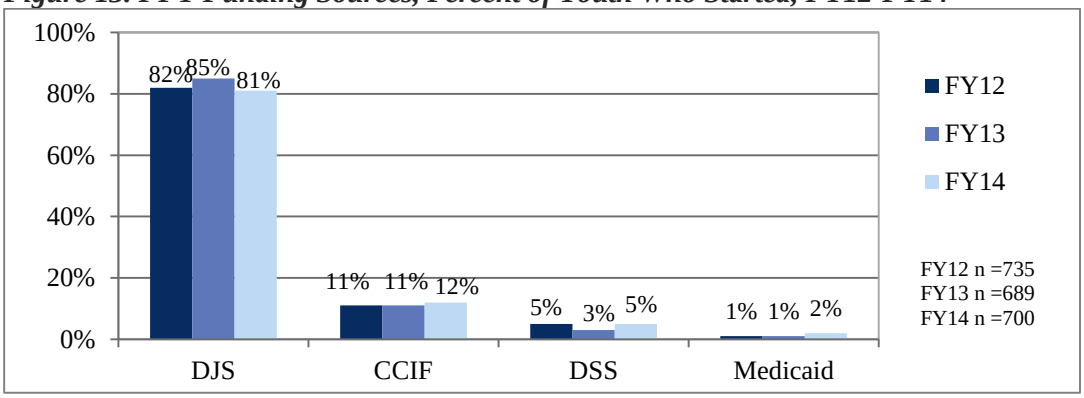


Figure 13. FFT Funding Sources, Percent of Youth Who Started, FY12-FY14



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.

Table 6. FFT Utilization, FY12-FY14

	FY12	FY13	FY14
Avg. Number of Funded Slots	323	310	310
Avg. Number of Active Slots	290	272	268
Avg. Daily Census	231	214	213
Avg. Utilization of Funded Slots	72%	69%	69%
Avg. Utilization of Active Slots	80%	79%	79%

In FY14, DJS, CCIF, and DSS collectively funded a daily capacity of 310 FFT slots across Maryland (Table 6). On average, 268 of these slots were "active", or available to youth and families for treatment. The average daily census of youth served by FFT was 213; thus, on average, 69% of funded slots, or 79% of active slots, were utilized. Both of these percentages have remained constant since FY13.

Characteristics of Youth Who Started

The characteristics of youth who started FFT were similar to those of the referral population. Most youth who started FFT in FY14 were between the ages of 15 and 17 years old (68%; Figure 14), and their average age was 15.9 years old. The majority of youth were male (72%) and African American/ Black (59%; Table 7). The characteristics of youth who started FFT have remained relatively stable over the past few years.

Figure 14. Ages, Percent of Youth Who Started FFT, FY14

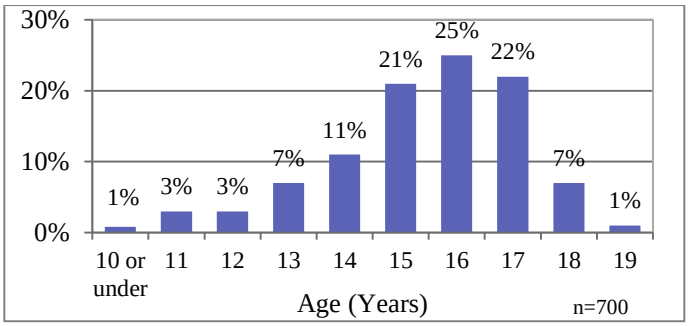
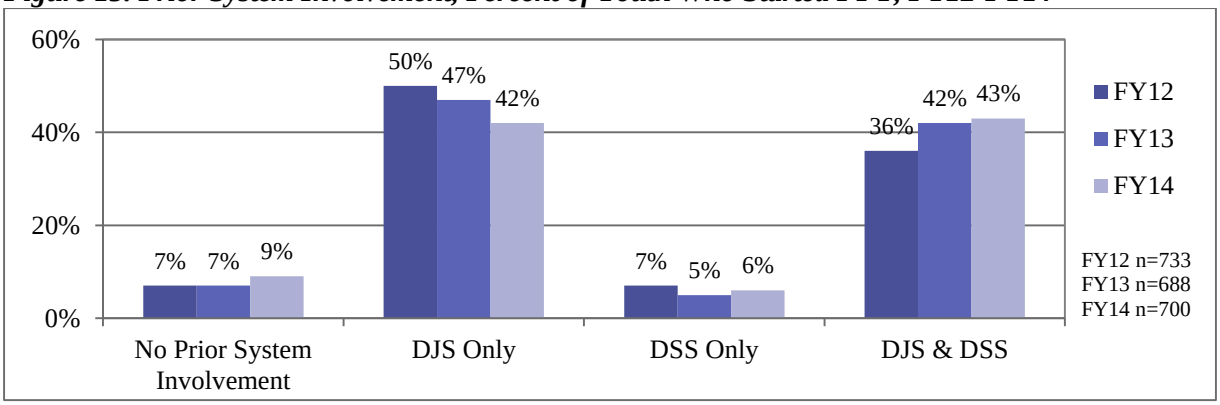


Table 7. Demographic Characteristics of Youth Who Started FFT, FY12-FY14

	FY12	FY13	FY14
Total Number of Youth	735	689	700
Male	74%	72%	72%
Female	26%	28%	28%
African American/Black	63%	64%	59%
Caucasian/White	25%	27%	28%
Hispanic/Latino	7%	5%	7%
Other	5%	4%	5%
Average Age (s.d.)	16.1 (1.7)	16.0 (1.7)	15.9 (1.8)

The majority (91%) of youth who started FFT in FY14 were currently or previously involved with DJS and/or DSS. Slightly more than two-fifths (43%) had some form of involvement with both systems (Figure 15); this proportion has been gradually increasing since FY12, when 36% of youth had prior involvement with both DJS and DSS.

Figure 15. Prior System Involvement, Percent of Youth Who Started FFT, FY12-FY14*



*Some youth could not be matched to DJS or DHR data due to missing identifiers (2 cases in FY12 and 1 case in FY13); it is possible additional youth were involved with DJS and/or DSS.

Involvement with the Juvenile Justice System

In order to describe youth's previous involvement with DJS, cases were matched with DJS's administrative data; only a small number of cases in FY12 (n=2) and FY13 (n=1) were missing information necessary for matching across systems. In FY14, 85% of matched youth had at least one prior complaint filed with DJS (Table 8)—a slight decrease from FY13, when 89% of youth had at least one prior complaint. Of those with previous DJS involvement, youth had, on average, five prior DJS complaints, and their average age at first complaint was 14.0 years old. Just under one-quarter (24%) of youth had at least one prior committed residential placement with DJS, and this subset of youth averaged 1.9 prior placements.

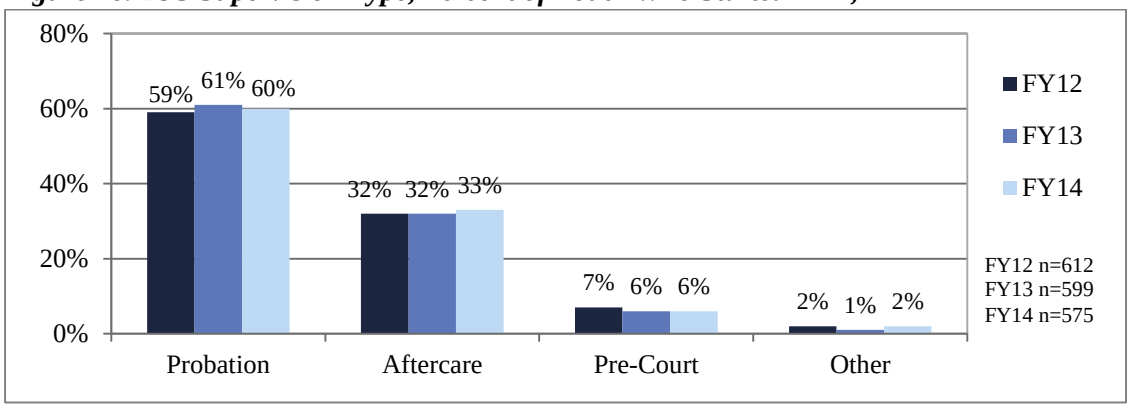
Table 8. Prior DJS Involvement, Percent of Youth Who Started FFT, FY12-FY14

	FY12	FY13	FY14
Total Number of Youth	735	689	700
Total Number of Matched Youth*	733	688	700
Any Prior DJS Complaints	86%	89%	85%
Avg. # of Prior DJS Complaints (s.d.)	5.0 (4.2)	4.5 (3.9)	4.7 (3.7)
Avg. Age at First DJS Complaint (s.d.)	13.9 (2.0)	13.9 (1.9)	14.0 (1.9)
Any Prior DJS Committed Residential Placements	22%	23%	24%
Avg. # of Prior DJS Committed Residential Placements (s.d)	1.7 (1.0)	1.6 (1.0)	1.9 (1.2)

*Some youth could not be matched to DJS data due to missing identifiers (2 cases in FY12 and 1 case in FY13); it is possible additional youth were involved with DJS.

Eighty-two percent of youth were actively involved with DJS when they started FFT—a slight decrease from prior fiscal years (84% in FY12; 87% in FY13). The type of DJS involvement/supervision has remained relatively stable over time, with the majority of youth being under probation or aftercare supervision (Figure 16). In the most recent reporting year, 60% of DJS-involved youth were under probation, 33% aftercare (i.e., committed to DJS), 6% pre-court, and 2% other supervision.[5] 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, 86 youths (16% of youth under aftercare or probation supervision) had been released from a committed residential placement within 30 days of starting FFT.

Figure 16. DJS Supervision Type, Percent of Youth Who Started FFT, FY12-FY14*



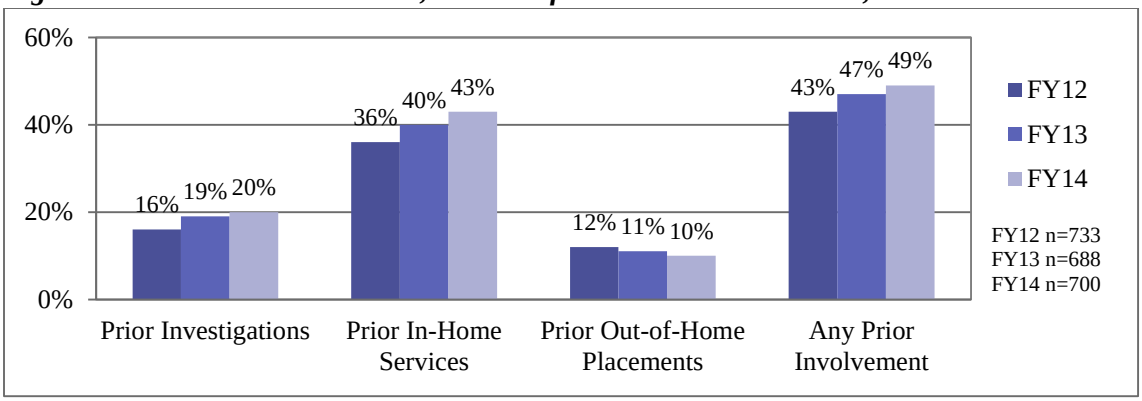
*Some youth could not be matched to DJS data due to missing identifiers (2 cases in FY12 and 1 case in FY13); it is possible that these additional youth were involved with DJS.

[5] Pre-court supervision occurs at intake when a youth and his/her family enter into an agreement with DJS to undergo counseling and/or informal DJS supervision without the involvement of the court. "Other" is largely comprised of youth under administrative supervision; these youth are usually transitioned into probation or aftercare supervision.

Involvement with the Child Welfare System

Youth were also matched with DHR's SACWIS (State Automated Child Welfare Information System) system in order to describe their previous experiences with DSS. Of the 700 youths who started FFT in FY14, 343 (49%) had some form of prior contact with the child welfare system (Figure 17). Prior to being referred to FFT, 140 (20%) youths were part of a prior DSS investigation,[6] 298 (43%) had received in-home services, and 73 (10%) had been placed out-of-home. On average, youth were 7.8 years old at the time of their first in-home service and 7.1 years old at the time of their first out-of-home placement.[7]

Figure 17. Prior DSS Involvement, Percent of Youth Who Started FFT, FY12-FY14



*Some youth could not be matched to DHR data due to missing identifiers (2 cases in FY12 and 1 case); it is possible additional youth were involved with DSS.

Simple bivariate analyses were conducted to determine if youth who started FFT differed from those who did not start (Figure 18). Notably, Hispanic/Latino youth were more likely to start FFT in FY14, as were those with no prior DJS referrals and those with DJS or Medicaid funding for treatment. Rates of starting FFT varied substantially by provider agency and jurisdiction; these figures can be found in Appendix 1.

Figure 18. Factors Related to Starting FFT in FY14

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

- ✓ Be Hispanic/Latino
- ✓ Have DJS or Medicaid funding for FFT
- ✓ Have no prior DJS complaints

Starting FFT was not statistically related to:

- x Gender
- x Age at referral
- x Having prior DJS committed residential placements
- x Having prior DSS involvement
- x Being waitlisted

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 ***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

[6] DSS investigations include cases that were indicated or unsubstantiated; because unsubstantiated cases can be expunged after 5 years, the number of investigations reported in this analysis may be under-counted.

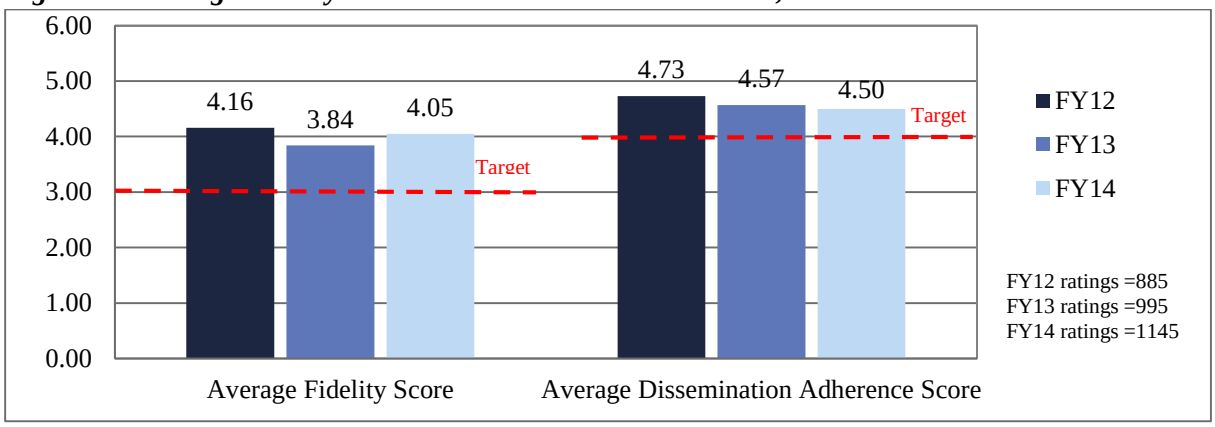
[7] Average age at first in-home service is based on 296 cases; two cases were excluded due to negative age values. Average age at first out-of-home placement is based on 72 cases; one case was excluded due to negative age values.

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 ***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 *program* (assessment protocol, attendance in supervision, completing documentation using the web-based system). Supervisors assess ratings based on the degree to which the therapist is completing all 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 19 illustrates the *Average Fidelity* and *Average Dissemination Adherence Scores* for all FFT teams in Maryland between FY12 and FY14. The average fidelity score increased from an average of 3.84 in FY13 to 4.05 in FY14, while the average dissemination score dropped slightly from 4.57 to 4.50; however, the teams continue to surpass the target scores.

Figure 19. Average Fidelity & Dissemination Adherence Scores, FY12-FY14*



*Only includes ratings from therapists tenured for six months or longer.

FFT Discharges & Outcomes

Of the 714 youths who were discharged from FFT in FY14, 658 (92%) were discharged for reasons *within therapist control*. The remaining 8% of cases were discharged for reasons *outside of therapist control* (note that these cases will not be included in subsequent analyses).[8] The specific discharge reasons falling under each category are listed in Figure 20.

Figure 20. FFT 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)

[8] Of the 56 youths who were discharged outside of therapist control in FY14, 21 discharged due to administrative reasons, 12 moved, 11 were placed for a prior event, eight were removed by the referral/funding source, and four discharged due to "other" reasons.

Upon discharge from FFT, each case is evaluated in three ways:

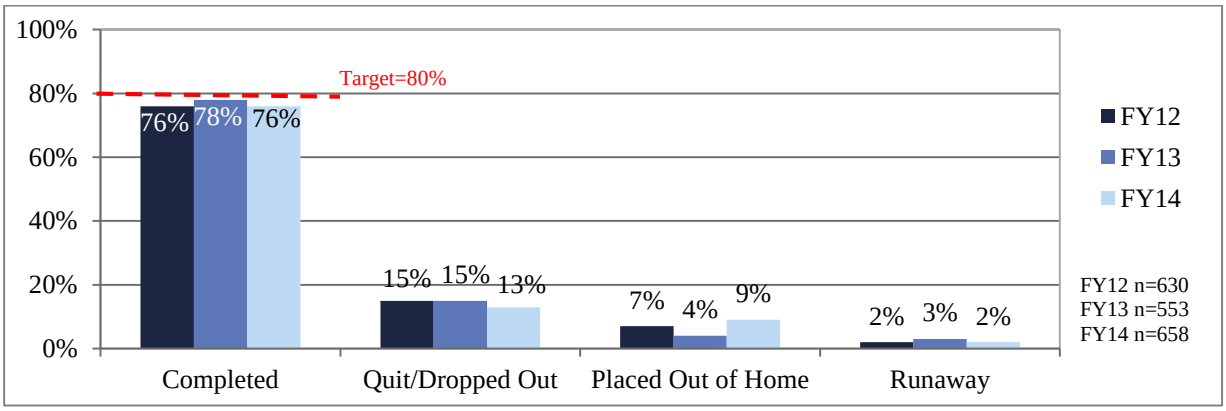
1) Did the youth and his/her family complete treatment (i.e., case progress)?
2) Were there sufficient changes in factors associated with problem behaviors (i.e., Outcome Questionnaire, Client Outcome Measure)?[9]
3) How was the youth doing in three primary areas of functioning at discharge (i.e., ultimate outcomes)?

Case progress and ultimate outcomes are addressed separately in this section.[10]

Case Progress at Discharge

The majority of youth *completed* FFT (76%, n=500; Figure 21). Though this outcome has remained stable for the past three fiscal years (76% in FY12 and 78% in FY13), it still falls slightly below the national purveyor's 80% target. Of the remaining cases discharged within therapist control, 13% discharged because the *youth/family quit or dropped out*, for 9% the *youth was placed out-of-home for a new event during FFT*,[11] and in 2% of cases the *youth ran away*.

Figure 21. Discharge Reasons, Percent of Youth Discharged within Therapist Control from FFT, FY12-FY14



Bivariate analyses indicate that African American/Black youth were significantly less likely to complete FFT (72%) than were Caucasian/White youth (80%) and youth of other races/ethnicities (86%) in FY14. Youth with no prior child welfare involvement were significantly more likely to complete treatment. There were also substantial variations by provider agency and jurisdiction (see Appendix 1).

Length of Stay

The average length of stay (ALOS) in FFT treatment was 117 days, meeting the national purveyor's target of 60-180 days (Figure 22). The ALOS was substantially longer for youth who completed treatment (128 days) as compared with those who did not complete (81 days).

Length of stay in FFT was related to several youth characteristics in FY14 (Table 9). Of those discharged within therapist control, the following types of youth had significantly longer lengths of stay: those who were younger, those who had no prior DJS complaints, those who had no prior DJS committed residential placements, and those placed on the waitlist. Length of stay varied substantially by funding source, with those funded by DJS having significantly shorter lengths of stay than those funded by CCIF or DSS. Differences in lengths of stay by agency and jurisdiction are provided in Appendix 1. Gender, race/ethnicity and prior DSS involvement were not statistically related to length of stay.

[9] FFT therapists routinely monitor each youth's behaviors and moods through assessments such as the Outcome Questionnaire (OQ) and Client Outcome Measure (COM).
[10] The Institute is working with FFT, Inc. to include data on changes in factors associated with problem behaviors in future reports.
[11] Out-of-home placements include, but are not limited to, substance abuse inpatient programs, group homes, or therapeutic group homes.

Figure 22. Length of Stay in FFT, Average Number of Days, FY12-FY14

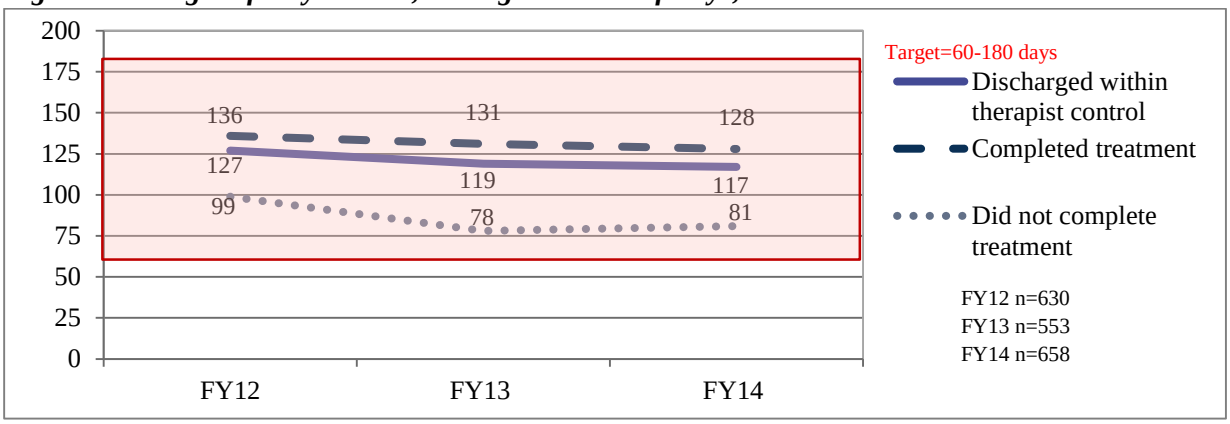


Table 9. Statistically Significant Differences in Lengths of Stay (LOS) in FY14

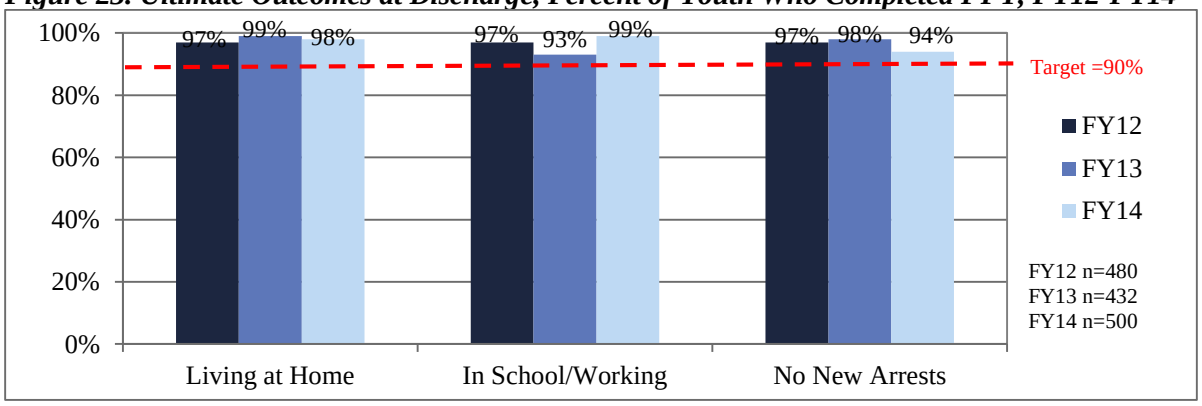
Factor	Shorter LOS	Longer LOS
Age at Admission	15 years and older (110.6)	Under 15 years old (135.5)
Prior DJS Complaints	Yes (110.2)	No (156.8)
Prior DJS Committed Residential Placements	Yes (102.3)	No (121.5)
Funding Source	DJS (108.2)	CCIF (164.9) DSS (134.8)
Waitlisted	No (111.1)	Yes (120.9)

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 23 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, 92% of completers in FY14 had positive results for all three outcomes. Success for all three outcomes varied by agency in FY14 but was not statistically related to gender, race/ethnicity, age, prior DSS involvement, or prior DJS involvement.

Figure 23. Ultimate Outcomes at Discharge, Percent of Youth Who Completed FFT, FY12-FY14



Juvenile and/or Criminal Justice System 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., schools). Although the ultimate outcomes indicate that just 6% of completers had new arrests during treatment, data provided by DJS and DPSCS indicate that 17% of completers had been referred to DJS/arrested while receiving FFT in FY14.[12] In addition, DJS data show that 9% of youth were admitted to a DJS detention facility during treatment.

Post-Discharge Outcomes

Subsequent Involvement with the Juvenile and/or Criminal Justice Systems

Research has shown that participation in FFT is associated with a reduced risk for delinquency and criminal behavior. In order to assess these outcomes post discharge, 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 FY11, FY12, and FY13, and matches were identified in their respective databases. Following DJS' recidivism criteria, subsequent involvement with the juvenile and adult criminal justice systems were categorized as referred to DJS/arrested, adjudicated delinquent/ convicted, and committed to DJS/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 (7 youth in FY11, 12 in FY12, and 6 in FY13).[13]

Juvenile & Criminal Justice System Measures*

Subsequent involvement with the juvenile and criminal justice systems are defined as follows:

Referred to DJS/Arrested refers to any DJS referral (including all complaints and violations of probation referred to DJS) or adult arrest.

Adjudicated Delinquent/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.

Committed to DJS/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.

**These measures exclude recidivism events outside of Maryland.*

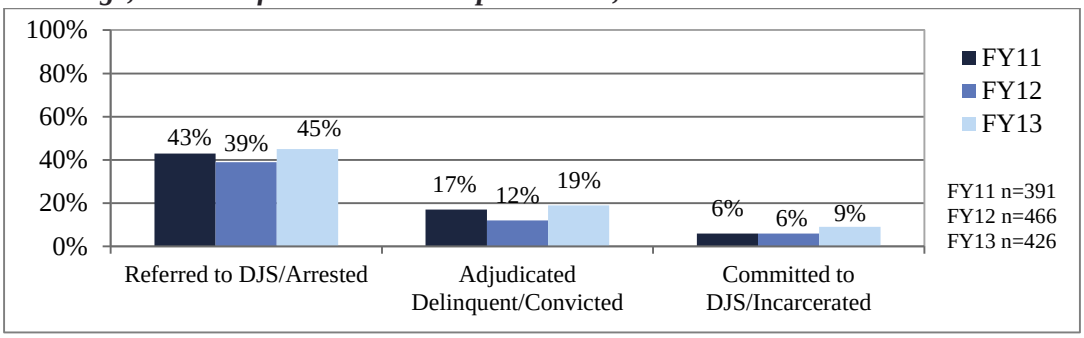
As shown in Figure 24, under half of youth who completed FFT were subsequently referred to DJS or arrested within one year of discharge (43% for FY11, 39% for FY12, and 45% for FY13); however, far fewer youth were ultimately adjudicated delinquent/convicted (17% for FY11, 12% for FY12, and 19% for FY13) and committed/ incarcerated for these arrests within one year (6% for FY11, 6% for FY12, and 9% for FY13). Notably, there was a slight increase in all justice system contact percentages for youth who completed FFT in FY13 compared to those for the two prior completion cohorts.

According to bivariate analyses using all FFT completers from FY11 through FY13, African American/Black youth, males, and those with one or more prior DJS complaints were significantly more likely to be referred to DJS/arrested within one year following their FFT discharge. Substantial differences were also evident by agency and jurisdiction (Appendix 1). Having a prior DJS commitment and prior DSS involvement were not statistically related to having a subsequent referral/arrest within one year.

[12] The percentage of youth who were referred to DJS/arrested (17%) includes youth who were referred to DJS for violations of probation and status offenses (using DJS's current definition for recidivism). When these offenses are excluded, the data indicate that 15% of completers were referred to DJS or arrested during treatment for felonies, misdemeanors, or incarcerable traffic offenses.

[13] Because incarceration start and release 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 24. Juvenile & Criminal Justice System Involvement within 12 Months Post-Discharge, Percent of Youth Who Completed FFT, FY11-FY13**



*Nine youths in FY11 and two youths in FY12 could not be matched to DJS data due to missing identifiers.

Table 10 summarizes subsequent involvement with DJS and/or DPSCS within 12 and 24 months for youth who completed FFT in FY11, FY12, and FY13. These numbers suggest that justice system involvement was driven primarily by contacts with the juvenile justice system, though 20% of FY11 completers and 17% of FY12 completers were arrested in the adult system within two years of discharge. Overall, 21% of the youth who completed FFT in FY12 had been adjudicated delinquent/convicted within 24 months of discharge, and only 11% of these youth were subsequently committed to DJS/incarcerated. Notably, the percentages of youth with subsequent justice system contact within 24 months are generally decreasing over time.

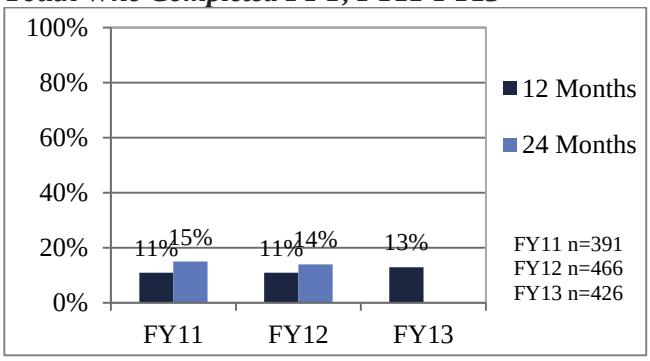
Table 10. Juvenile & Criminal Justice System Involvement within 12 and 24 Months Post-Discharge, Percent of Youth Who Completed FFT, FY11-FY13

		FY11 (n=391)			FY12 (n=466)			FY13 (n=426)		
		Ref./ Arrest	Adj./ Convict.	Comm./ Incar.	Ref./ Arrest	Adj./ Convict.	Comm./ Incar.	Ref./ Arrest	Adj./ Convict.	Comm./ Incar.
DJS	12 Months	36%	14%	3%	33%	11%	4%	33%	15%	5%
	24 Months	41%	20%	8%	40%	17%	7%	--	--	--
DPSCS	12 Months	10%	3%	3%	8%	2%	2%	14%	4%	4%
	24 Months	20%	7%	6%	17%	4%	4%	--	--	--
DJS/ DPSCS	12 Months	43%	17%	6%	39%	12%	6%	45%	19%	9%
	24 Months	54%	26%	14%	50%	21%	11%	--	--	--

*Nine youths in FY11 and two youths in FY12 could not be matched to DJS data due to missing identifiers.

DJS Committed Residential Placements. 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. [14] Consequently, more youth may be admitted to a residential placement following discharge from FFT than indicated by rates of commitment (shown above). Eleven percent of the matched youth who completed FFT in FY11 and FY12, and 13% of the matched youth who completed in FY13, were admitted to a residential placement by DJS during the twelve months following discharge (Figure 25). When the follow-up period is extended to two years,

Figure 25. DJS Committed Residential Placement within 12 and 24 Months Post-Discharge, Percent of Youth Who Completed FFT, FY11-FY13*



*Nine youths in FY11 and two youths in FY12 could not be matched to DJS data due to missing identifiers.

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

the majority of youth still avoided post-discharge residential placement admissions; 15% of the youth who completed in FY11 and 14% of the youth who completed in FY12 were admitted to a committed residential placement by DJS within 24 months of discharge from FFT.[15]

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 FY13 in order 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 432 youths who completed FFT in FY13, 7% had some form of DSS contact within 12 months of discharge—six youths (1%) had a new DSS investigation, 19 (4%) received in home services, and 11 (3%) were placed out-of-home (Table 11). Of FFT completers in FY11 and FY12, 10% and 8%, respectively, had some form of new DSS contact within 24 months of discharge.

Table 11. Child Welfare System Involvement within 12 and 24 Months Post-Discharge, Percent of Youth Who Completed FFT, FY11-FY13*

	FY11 (n=399)			FY12 (n=478)			FY13 (n=432)		
	Invest-igation	In-Home Service	Out-of-Home Plcmt	Invest-igation	In-Home Service	Out-of-Home Plcmt	Invest-igation	In-Home Service	Out-of-Home Plcmt
12 Months	4%	3%	3%	2%	4%	2%	1%	4%	3%
24 Months	5%	5%	3%	3%	4%	3%	--	--	--

*Eight youth in FY11 and one youth in FY12 could not be matched to DHR data due to missing identifiers.

Cost of FFT in Maryland

In FY14, the total service delivery cost for providing FFT in Maryland was $2,709,739. The service delivery cost is based on payments to service providers and expenses incurred for training, coaching, and fidelity monitoring in FY14. Although there were variations in expenditures across the different providers, on average, the cost of administering FFT was $3,795 per discharged youth (Table 12).

Table 12. Service Delivery Cost of FFT in Maryland, FY14

	FY14
Number of Discharged Youth	714
Service Cost per Youth	$3,795
Total Service Delivery Cost	$2,709,739

Cost Analysis for DJS-Funded Youth

One of the applications of FFT is to prevent placement in more restrictive settings among high-risk youth. Although youth served by FFT can be funded by a variety of sources (i.e., DJS, DSS, and CCIF), the majority of the youth is funded by DJS. Table 13 highlights the average per diem rates reimbursed by DJS for different placement types and the resulting average cost per stay based on the average length of stay of DJS-funded youth. The average per diem rates are based on the contracted amounts between the service provider and DJS. The average per diem rates of the placements examined ranged from $160 for treatment foster care to $572 for hardware secure youth centers, with the FFT average per diem rate for DJS-funded youth at $33.[16] A cost analysis shows that FFT has the potential to provide substantial returns on investments. For example, the investment in FFT by DJS was 4% of the average cost per stay of hardware secure youth centers and 8% of the average cost per stay of group homes.

[15] These percentages do not include youth who were residing in a secure facility at discharge from FFT.
[16] In order to compare cost with DJS rates, the estimated costs for FFT do not include expenses for training, coaching, and implementation data monitoring. The DJS rates derived from *DJS's Fiscal Year 2014 Data Resource Guide* do not include these expenses.

Table 13. Cost Analysis of FFT and Placements for DJS-Funded Youth, FY14 [1]

	Average Length of Stay (Days)	Average Per Diem Rate	Average Cost per Stay/Treatment
FFT	105	$33	$3,431[2]
Treatment Foster Care	241[3]	$160	$38,548
Group Homes	202	$210	$42,402
DJS Staff-Secure Facilities	142	$378	$53,708
DJS Hardware-Secure Facilities	146	$572	$83,480

[1] Data used for calculations for Treatment Foster Care, Group Homes, and Staff Secure and Hardware Secure Youth Centers are *derived from DJS's Fiscal Year 2014 Data Resource Guide.*

[2] The average cost per stay/treatment for DJS-funded youths differs from the overall average cost per youth for adminstering FFT in Maryland since the DJS per diem rates data for FFT did not include expenses for training, coaching, and implementation data monitoring.

[3] The ALOS includes both traditional and treatment foster care placements.

FY14 FFT Implementation in Maryland: Successes & Challenges

Utilization

- The percentage of referred youth who started FFT has remained at 67% or greater since FY12; youth funded by DJS, DHR/DSS, or Medicaid are significantly more likely to start treatment than those whose funding is provided through the CCIF/LMB.
- The average utilization rate was 69% for funded slots and 79% for active slots. Utilization remained the same since FY13 and the 90% target for the state was not achieved.
- Half of the 323 youths who did not start FFT in FY14 was due to difficulty contacting the family or gaining consent for treatment. Greater effort should be expended to educate parents on the goals of the program and to encourage participation.
- The global admission length has slightly increased over time, and, on average, youth and families started treatment within three to four weeks of referral during FY14. Global admission lengths were significantly longer for females, older youth, those with no prior referrals to DJS, those with no prior DSS involvement, youth funded by CCIF, and youth who spent time on the waitlist.
- The percentage of youth who were placed on the waitlist increased from 38% of all referrals in FY13 to 55% in FY14. Two-thirds (67%) of waitlisted youth were placed on the waitlist because the program was operating at capacity.

Fidelity

- The *Average Fidelity Score* and the *Average Dissemination Adherence Score* both exceeded the FFT national target, with fidelity increasing from 3.84 to 4.05 and dissemination adherence decreasing from 4.57 to 4.50.
- The average length of stay in FFT was 117 days—well within the national purveyor's target of 60-180 days.

Outcomes

- Seventy-six percent of youth discharged within therapist control had completed treatment in FY14, similar to 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 92% achieved success for all three of the outcomes as of discharge.
- Although the ultimate outcomes indicate that just 6% of completers had new arrests during treatment, data provided by DJS and DPSCS indicate that 17% of completers had been referred to DJS/arrested while receiving FFT in FY14. Note that the DJS recidivism data includes violations of probation and status offenses,

and the percentage is revised to 15% if just accounting for felony, misdemeanor, and incarcerable traffic offenses.

- Involvement with the juvenile and/or criminal justice systems during the 12 months post-discharge increased slightly for FY13 completers compared to the FY11 and FY12 cohorts. Though 45% of the youth who completed in FY13 were referred to DJS/arrested within one year of discharge, less than 20% were subsequently adjudicated delinquent/convicted, and 9% were subsequently committed to DJS/incarcerated. Slightly higher percentages of youth who completed FFT in FY11 (54%) and FY12 (50%) were referred to DJS or arrested as adults within two years of discharge.
- Eighty-seven percent of the youth who completed FFT in FY13 were not admitted to a DJS residential facility in year following treatment completion.
- Very few youth (7%) who completed FFT in FY13 had new involvement with DSS in the year following discharge. Based on findings for FY11 and FY12 cohorts, less than 10% of FFT completers had some form of new DSS contact within two years following discharge.

Costs

- The average cost per treatment of FFT was only 4% of the average cost per stay of hardware-secure youth centers and 8% of the average cost per stay of group homes.

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*. Boulder, CO: 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.