BRIEF STRATEGIC FAMILY THERAPY IN MARYLAND: FY 2014 IMPLEMENTATION REPORT

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EXECUTIVE SUMMARY

Brief Strategic Family Therapy (BSFT) is one of five prioritized evidence-based practices selected by Maryland's Children's Cabinet with the goal of providing empirically-supported community-based practices that address key outcomes for youth and families (e.g., delinquency, family functioning, etc.). Since fiscal year (FY) 2011, The Institute for Innovation & Implementation has supported BSFT implementation in Maryland, providing technical assistance and data reporting to providers and stakeholders. The following report summarizes BSFT utilization, fidelity, and outcomes in Maryland for FY14.

FY14 Data Highlights

Utilization

- BSFT was available in three jurisdictions throughout Maryland—Baltimore, Carroll, and Prince George's Counties—though the program in Prince George's County closed in June 2014.
- Of the 79 youths who started BSFT in FY14, nearly three-fourths were referred by the provider's agency (37%) and parents/families (34%).
- The average age of youth who started BSFT was 12.9 years old, and the majority of youth were Caucasian/ White (61%) and male (53%).
- The majority of youth had no previous involvement with the Department of Social Services (75%) or Department of Juvenile Services (DJS; 92%).
- On average, youth and families started treatment within three weeks of referral.

Fidelity

- The percentage of youth served by fully certified therapists remained relatively stable from FY13 (87%) to FY14 (83%).
- On average, youth attended 12 BSFT sessions over 149 days in FY14, compared to 13 sessions over 153 days in FY13.

Outcomes

- In FY14, 73 youths were discharged from BSFT for reasons within the therapist's control, and **67% completed treatment.** This represents a decline from FY13, when 85% of discharged youth completed treatment.
    - Of the 24 youths who did not complete BSFT, the most frequent discharge reason was *quit/ dropped out* (83%); this outcome was particularly prominent in the discontinued BSFT program in Prince George's County.
- Of youth who completed BSFT in FY14, at the time of discharge:
    - **100%** were living at home;
    - **96%** were in school or working; and
    - **96%** had no new arrests.
- Of the youth who completed BSFT in FY13, as of one year post-discharge:
    - **88%** had not been referred to DJS/arrested;
    - **96%** had not been adjudicated delinquent/convicted;
    - **99%** had not been committed to DJS/incarcerated;
    - **98%** had no new involvement with the child welfare system.

Introduction

Purpose of this Report

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

The Institute for Innovation & Implementation (The Institute) collects and analyzes data for a variety of EBPs implemented throughout Maryland. This report provides State and local stakeholders with a summary of BSFT implementation across the State for fiscal year (FY) 2014. In addition to utilization and fidelity indicators, both short- and long-term outcomes for participating youth are examined.

What is an EBP?

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

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

What is Brief Strategic Family Therapy?

BSFT is a short-term, family-based treatment program for youth ages 6 through 17 who are displaying or at risk for developing behavior problems, including early substance use, conduct problems, truancy, association with problem peers, and delinquency. The primary goals of BSFT are to 1) prevent, reduce, and/or treat youth problem behavior, and 2) to improve family functioning (Brief Strategic Family Therapy Institute, 2015a).

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

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

Table 1. BSFT Ratings on National EBP Registries*

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

*Ratings as of February 2015. **The scale range from 0 to 4.

BSFT Implementation Support

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

Assessing BSFT Utilization and Outcomes

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

- ***Utilization data*** include demographic information, delinquency history, child welfare system history, and details of case processing (e.g., referral sources, waitlist information, etc.). As a whole, utilization data indicate the "who, when, and why" for youth served by BSFT.
- ***Fidelity data*** measure the degree to which BSFT has been delivered as intended by the program developers.
- ***Outcomes data*** allow us to assess whether BSFT has achieved the desired results for youth and families (Table 2). The outcomes of particular interest in BSFT include engaging in and completing treatment, reducing or eliminating youth substance use, decreasing delinquent behaviors and conduct problems, and improving family functioning (Brief Strategic Family Therapy Institute, 2015b). Whereas data

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

regarding substance use and family functioning were not available for this report, other outcomes were measured using information collected by providers at treatment discharge and administrative data collected by State child-serving agencies.

Table 2. BSFT Outcomes Data—Types and Sources

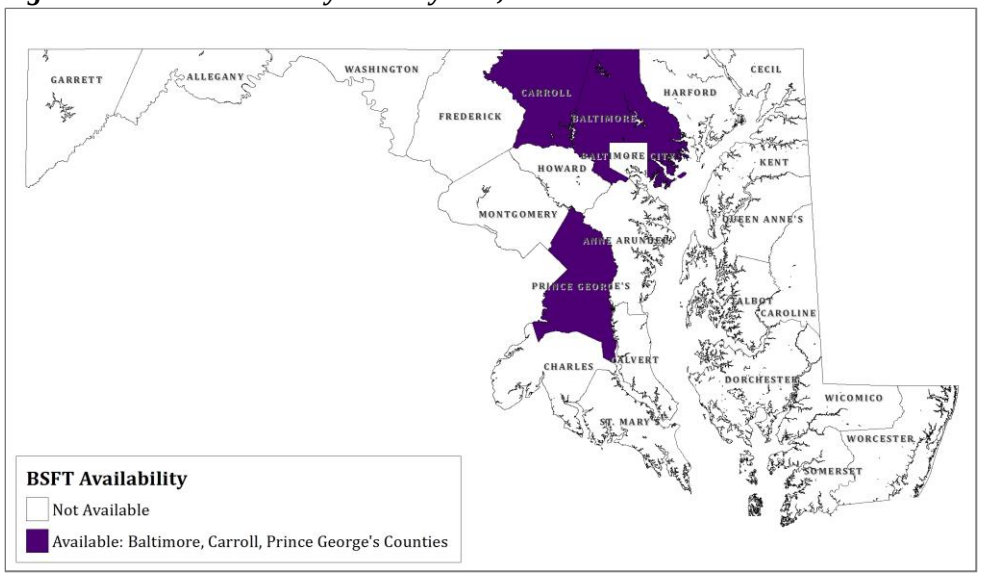
Type	Indicator	Source
Case Progress	➢ Treatment completion ➢ Reason for non-completion (if applicable)	BSFT Providers
Ultimate Outcomes at Discharge	➢ Whether the youth was living at home ➢ Whether the youth was in school or working ➢ Whether the youth had any new arrests	BSFT Providers
Post-Discharge 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. Please refer to Appendix 1 for FY14 descriptive data presented by provider and jurisdiction.

Where was BSFT Offered in Maryland?

In FY14, BSFT was offered in three counties in Maryland—Baltimore, Carroll, and Prince George's (Figure 1). BSFT was administered by three providers—Catholic Charities (Baltimore County), CCYSB (Carroll County), and DHFYSC (Prince George's); however, DHFYSC closed their BSFT program in June 2014.

Figure 1. BSFT Availability in Maryland, FY14



Youth Who Started BSFT

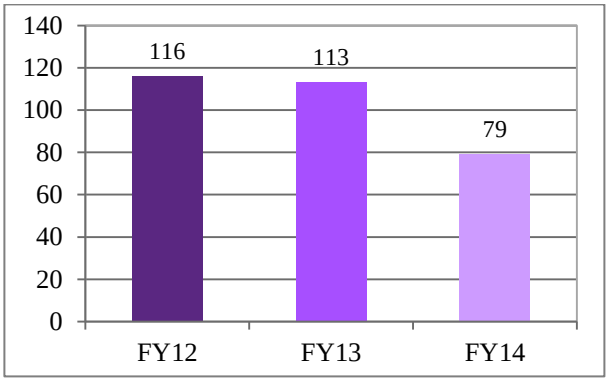
Referral Sources

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

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

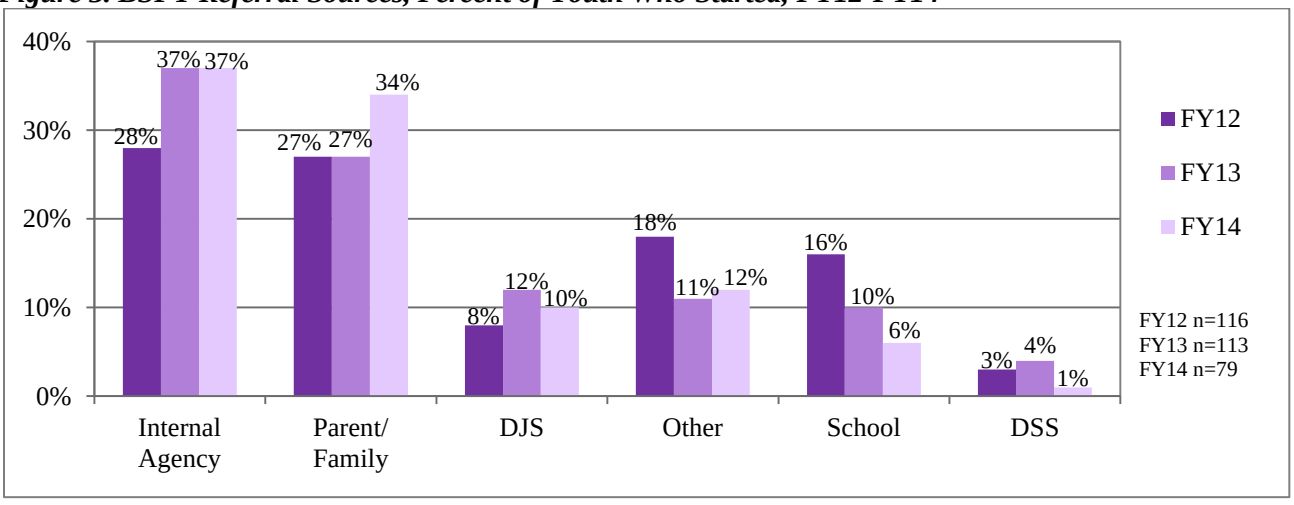
In FY14, 79 youths started BSFT in Maryland, compared with 116 youths in FY12 and 113 youths in FY13 (Figure 2). This decline was largely driven by DHFYSC's reduced capacity prior to discontinuing BSFT at the end of FY14.

Figure 2. Number of Youth Who Started BSFT, FY12-FY14



The majority of the 79 youths who started the program were referred internally by the BSFT provider agency (37%; also referred to as "internal agency") or by parents/family (34%), followed by other sources (12%), and DJS (10%; Figure 3).[2] Internal agency referrals have been the principal referral source over the past few years.

Figure 3. BSFT Referral Sources, Percent of Youth Who Started, FY12-FY14



[2] Other sources include, but are not limited to, crisis response programs, police, and mental health agencies.

Funding Sources

For 60% (n=47) of youth, their participation in BFST was primarily funded by Medicaid, and an additional 24% (n=19) of youth had their treatment paid for by private insurance (Figure 4).[3]

Waitlisted Youth

In FY14, only one (1%) youth was placed on the waitlist—down from 25 (22%) in FY12 and 10 (9%) in FY13 (Figure 5). DHFYSC was the only provider to place youth on a waitlist, and the FY14 decline in the number of waitlisted youth coincided with that provider's decision to discontinue provision of BSFT. Across all three years, youth were placed on the waitlist almost exclusively because the program was operating at capacity, and this was the reason provided for the youth who was waitlisted in FY14.

Global Admission Length (Initial Case Processing)

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

The average global admission length decreased from 17 weekdays in FY12 to 15 weekdays in both FY13 and FY14 (Figure 6). Although bivariate analyses indicate differences across agencies and jurisdictions (Appendix 1), there were no statistically significant differences in the global admission lengths by subgroups of youth (e.g., by gender, race/ethnicity).

Figure 4. Primary BSFT Funding Sources, Percent of Youth Who Started, FY14

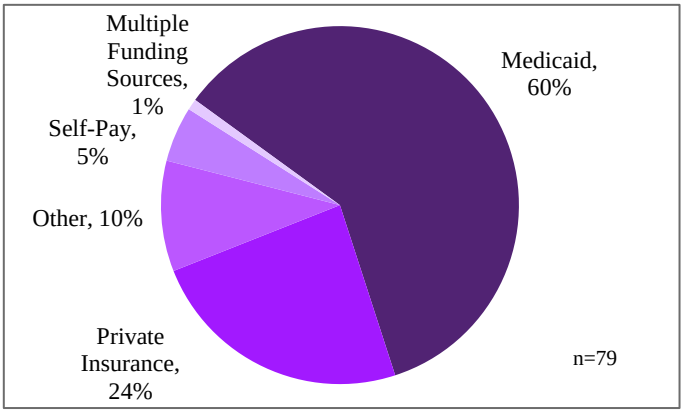


Figure 5. Youth Placed on Waitlist, Percent of Youth Who Started BSFT, FY12-FY14

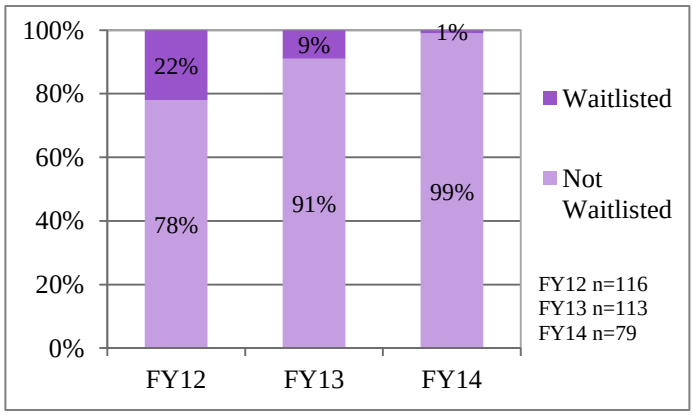
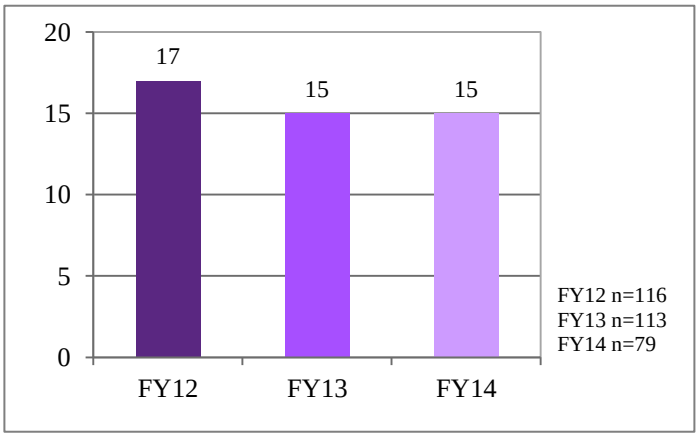


Figure 6. Global Admission Length, Average Number of Weekdays, FY12-FY14

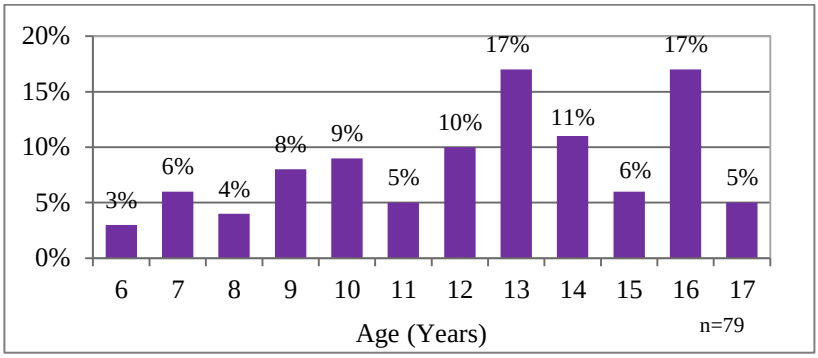


[3] Data on the primary funding source was not collected prior to FY14.

Characteristics of Youth

BSFT can serve male and female youth from diverse racial and ethnic backgrounds between the ages of 6 and 17 years old. Slightly more than half of the youth who started BSFT in FY14 were between the ages of 13 and 16 years old (51%; Figure 7), and their average age was 12.9 years old. The majority of youth were male (53%) and Caucasian/White (61%; Table 3).

Figure 7. Ages, Percent of Youth Who Started BSFT, FY14



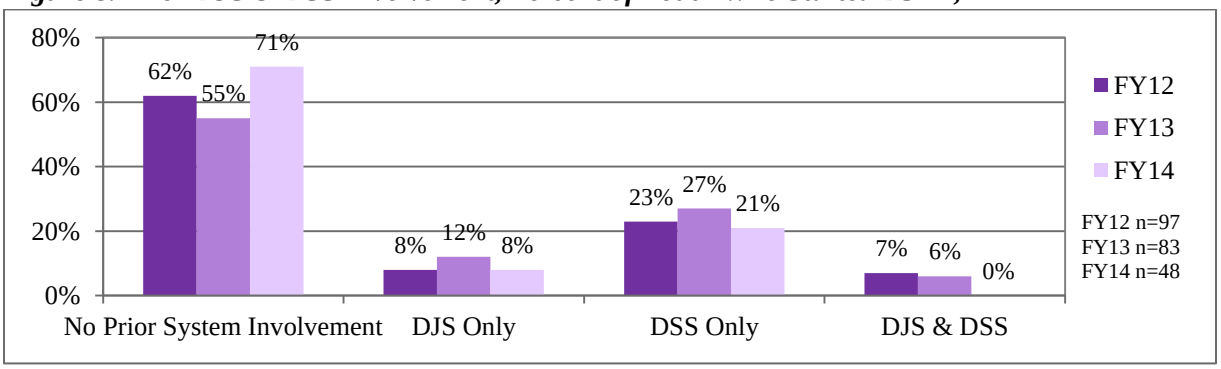
The characteristics of youth who started BSFT have changed somewhat over the past three fiscal years. Most notably, a smaller proportion of African American/Black youth and a greater proportion of youth of Caucasian/White and other racial/ethnic backgrounds were admitted in FY14 relative to FY12. These changes are attributable, in part, to a further decline in admissions by DHFYSC, which served primarily African-American/Black youth. Additionally, a smaller proportion of males were admitted in FY14 (53%) than in the year prior (64%).

Table 3. Demographic Characteristics of Youth Who Started BSFT, FY12-FY14

	FY12	FY13	FY14
Total Number of Youth	116	113	79
Male	59%	64%	53%
Female	41%	36%	47%
African American/Black	51%	30%	23%
Caucasian/White	40%	61%	61%
Hispanic/Latino	1%	0%	1%
Other	9%	9%	15%
Average Age (s.d.)	12.9 (2.8)	13.1 (3.2)	12.9 (3.0)

In order to describe youth's previous involvement with the child welfare and juvenile justice systems, cases were matched to administrative data maintained by DHR and DJS, respectively. Thirty-one (39%) youths who started BSFT in FY14 were missing the identifiers necessary to link their data across systems. Of the remaining 48 youths whose data were matched, the majority (71%) had no involvement with either DSS or DJS, 21% were previously or currently involved with DSS, 8% had been referred to DJS, and no youth were indicated as having been dually involved with both systems (Figure 8).

Figure 8. Prior DJS & DSS Involvement, Percent of Youth Who Started BSFT, FY12-FY14*



*Many youth could not be matched to DJS and DHR data due to missing identifiers (19 cases in FY12, 30 cases in FY13, and 31 cases in FY14); it is possible additional youth were involved with DJS and DSS.

Involvement with the Juvenile Justice System

In FY14, of the 48 youths who started BSFT and whose names could be matched to DJS' administrative data, only 8% had at least one prior complaint filed with DJS; this represents a lower percentage than was evident in either FY12 (16%) or FY13 (18%; Table 4). Of those with previous DJS involvement, youth who started BSFT in FY14 had, on average, one prior DJS complaint, and their mean age at first referral was 13.6 years old. None of the matched youth who started BSFT in FY14 had been previously committed to DJS for residential placement.

Table 4. Prior DJS Involvement, Youth Who Started BSFT, FY12-FY14

	FY12	FY13	FY14
Total Number of Youth	116	113	79
Total Number of Matched Youth*	97 (84%)	83 (73%)	48 (61%)
Any Prior DJS Complaints	16%	18%	8%
Avg. # of Prior DJS Complaints (s.d.)	1.2 (0.6)	2.3 (2.3)	1.3 (0.5)
Avg. Age at First DJS Complaints (s.d.)	13.3 (2.3)	12.7 (1.9)	13.6 (2.9)
Any Prior DJS Committed Residential Placements	0%	0%	0%

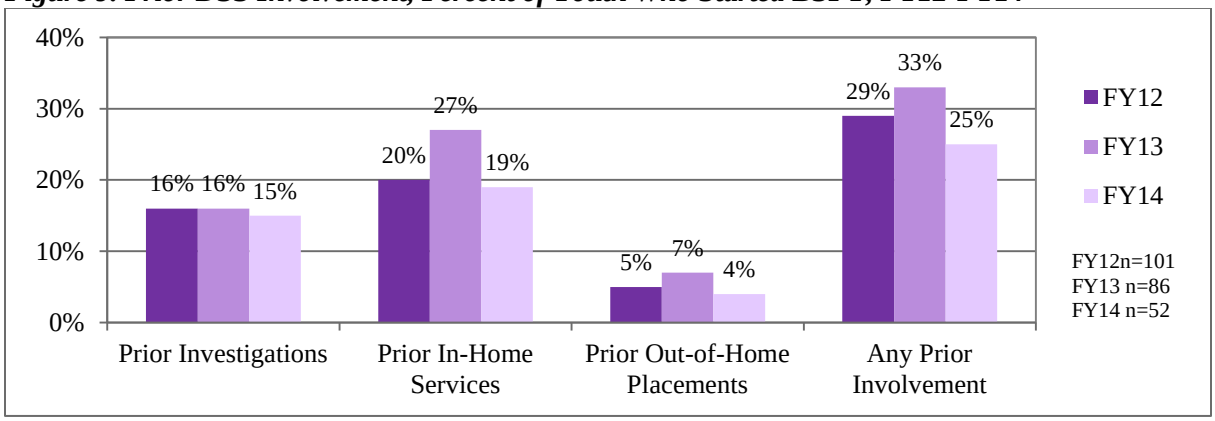
*Many youth could not be matched to DJS data due to missing identifiers (19 cases in FY12, 30 cases in FY13, and 31 cases in FY14); it is possible additional youth were involved with DJS.

Of youth who matched to DJS' administrative data, very few were actively involved with DJS upon starting BSFT, decreasing from nine (11%) youths in FY13 to three (6%) youths in FY14. All three youths were under pre-court supervision.[4]

Involvement with the Child Welfare System

Of the 52 youths who started BSFT in FY14 and who could be matched to DHR's administrative data, 13 (25%) had some form of prior contact with Maryland's child welfare system (Figure 9), including Child Protective Services investigations, in-home services, and/or out-of-home placements prior to their BSFT referral.[5] Specifically, eight (15%) youths were part of a prior DSS investigation, ten (19%) youths had received in-home services, and two (4%) youths had been placed out-of-home. On average, youth were 5.2 years old at the time of their first in-home service and 3.7 years old at the time of their first out-of-home placement.

Figure 9. Prior DSS Involvement, Percent of Youth Who Started BSFT, FY12-FY14



*Many youth could not be matched to DSS data due to missing identifiers (15 cases in FY12, 27 cases in FY13, and 27 cases in FY14); it is possible additional youth were involved with the child welfare system.

[4] 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.

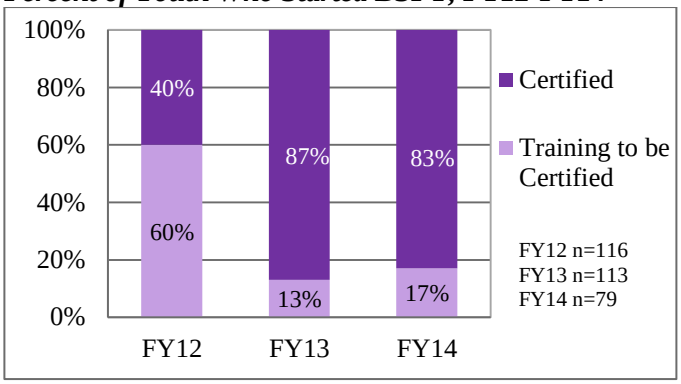
[5] DSS investigations include cases that were indicated or unsubstantiated; because unsubstantiated cases can be expunged after 5 years, the number of investigations reported in this analysis may be under-counted.

BSFT Model Fidelity

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

Standardized fidelity measures were not available for inclusion in this report; however, therapist certification status is tracked on an ongoing basis. Figure 10 illustrates the BSFT therapist certification status for each youth who started therapy between FY12 and FY14. The percentage of youth served by certified therapists remained relatively stable between FY13 (87%) and FY14 (83%).

Figure 10. BSFT Therapist Certification Status, Percent of Youth Who Started BSFT, FY12-FY14



BSFT Discharges & Outcomes

Of the 86 youths who were discharged from BSFT in FY14, 73 (85%) were discharged for reasons *within therapist control*. The remaining 15% of cases were discharged for reasons *outside of therapist control* (note that these cases will not be included in subsequent analyses).[6] The specific discharge reasons falling under each category are listed in Figure 11.

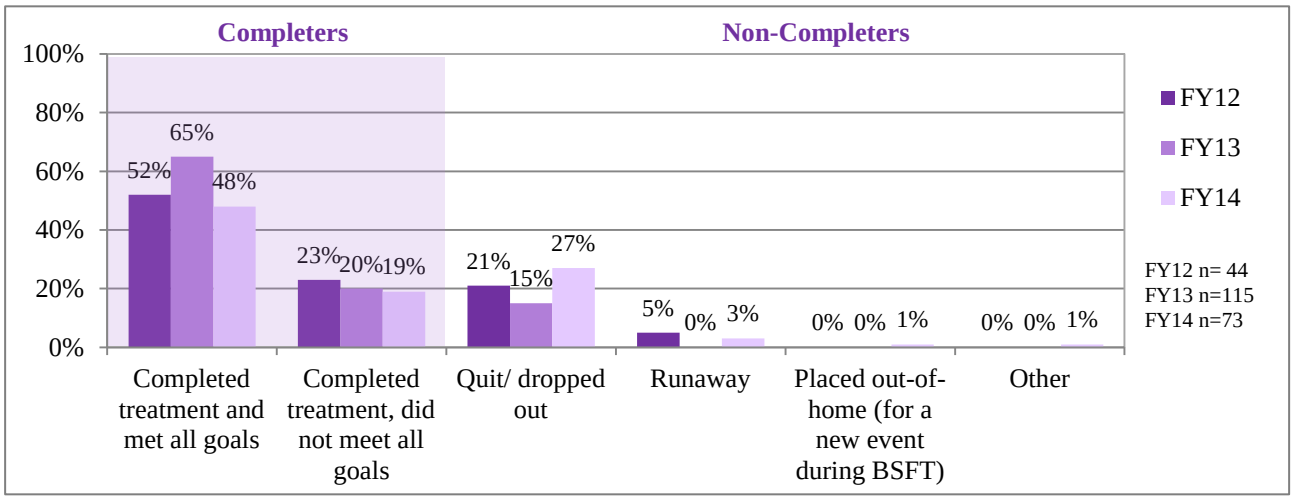
Figure 11. BSFT Discharge Reasons

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

As shown in Figure 12, two-thirds (67%, n=49) of youth completed BSFT, a decrease from FY12 (75%, n=33) and FY13 (85%, n=98). In addition, approximately half (48%) of youth completed treatment *and* met all treatment goals. Of those who did not complete treatment, the most common discharge reason was *quit/ dropped out* (27% of all youth discharged within therapist control in FY14). Preliminary analyses reveal significant differences in completion by agency/jurisdiction (Appendix 1) but not by the youth characteristics examined in this report. Further, the BSFT program in Prince George's County, which closed in June 2014, had the highest rate of discharges due to *quit/dropped out*.

[6] Of youth discharged for reasons *outside of therapist control*, six were referred to other services, five were discharged for administrative reasons, and two were discharged for "other" reasons.

Figure 12. Discharge Reasons, Percent of Youth Discharged within Therapist Control from BSFT, FY12-FY14



Average Number of Sessions and Length of Stay

BSFT providers conduct treatment sessions in both the client's home and office settings, though the primary location varies by provider. Figures 13 and 14 show the average number of sessions and the average lengths of stay for youth discharged within therapist control from FY12 through FY14. Overall, youth who were discharged from BSFT in FY14 attended an average of 11.7 sessions over the course of 149 days in treatment. Those who completed the program attended a greater number of sessions (15.1) and were in treatment longer (173 days) than youth who did not complete BSFT, who attended an average of 4.8 sessions over the course of approximately 101 days. The average number of sessions for both completers and all youth discharged within therapist control were within the national purveyors' target ranges (approximately 12-16 sessions). It is also notable that the number of sessions attended by completers has been increasing since FY12.

Figure 13. Average Number of BSFT Sessions, Youth Discharged within Therapist Control, FY12-FY14

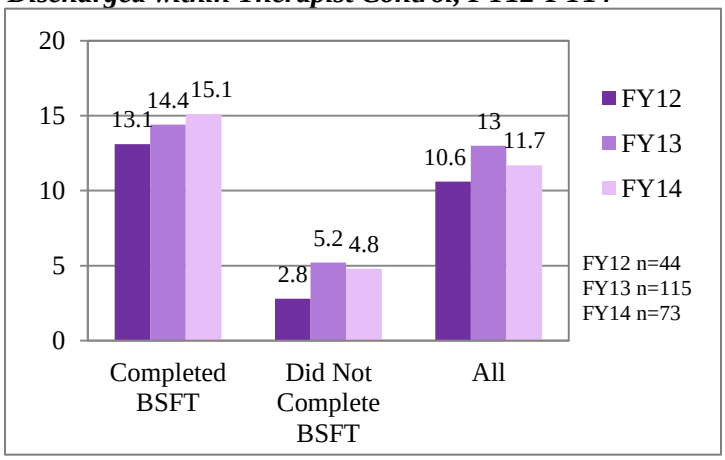
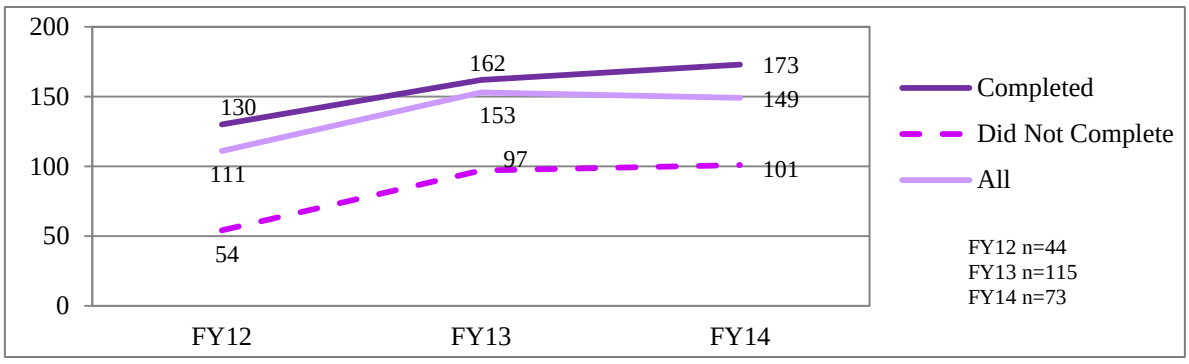


Figure 14. Average Length of Stay in BSFT (Days), Youth Discharged within Therapist Control, FY12-FY14



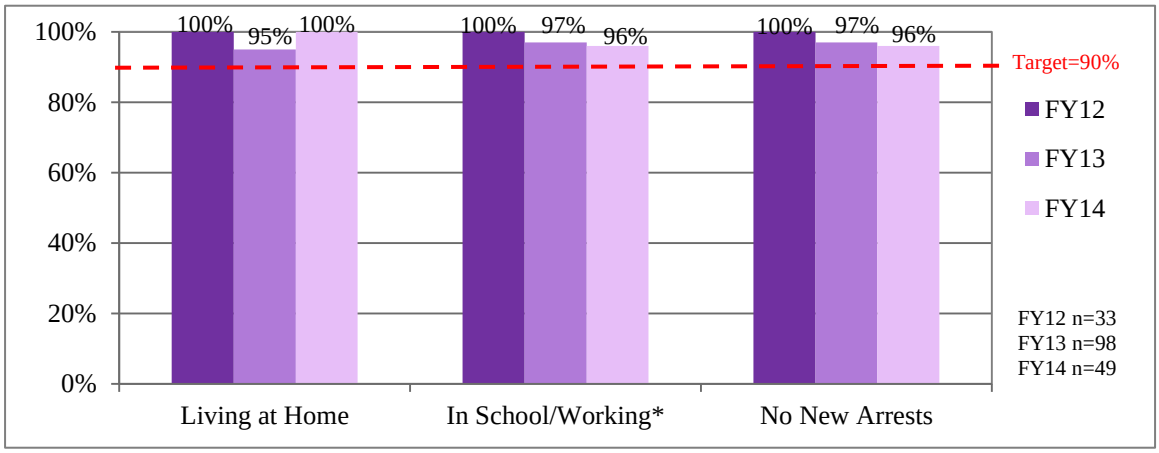
Significant differences in the length of stay were also apparent with respect to gender, with males spending more time in treatment (173 days) than females (121 days), and race/ethnicity, with Caucasian/White youth (171 days) spending significantly more days in treatment relative to youth of "other" races/ethnicities (83 days), on average. Substantial differences were also evident by agency/county (see Appendix 1). There were no significant differences in the length of stay related to therapist certification.

Ultimate Outcomes at Discharge

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

Figure 15 shows the ultimate outcomes for youth who completed BSFT (including both those who met all goals and those who did not) over the past three years. Maryland's target is 90% success for each ultimate outcome (i.e., 90% of youth who complete BSFT will attain each discharge outcome); this goal has been achieved since FY12. Further, 94% of completers in FY14 had positive results for all three outcomes.

Figure 15. Ultimate Outcomes at Discharge, Percent of Youth Who Completed BSFT, FY12-FY14



*In school/working was not collected by DHFYSC until July 2013.

Juvenile and/or Criminal Justice System Involvement during Treatment

The ultimate outcomes are reported by BSFT therapists, who may not be aware of all youth contacts with law enforcement or the juvenile justice system. And not all contacts with the system may be the result of an arrest—youth may also be referred to DJS from other sources (e.g., school). However, consistent with what was reported by BSFT therapists, data provided by DJS and DPSCS indicate that only one youth who completed treatment had been referred to DJS/arrested while receiving BSFT in FY14.[7]

[7] Eighteen youths could not be matched to DJS/DPSCS data due to missing identifiers; it is possible that additional youth were involved with DJS/DPSCS.

Post-Discharge Outcomes

Subsequent Involvement with the Juvenile and/or Criminal Justice Systems

In order to assess post-discharge outcomes in Maryland, The Institute provided DJS and DPSCS with the name, gender, race/ethnicity, and date of birth of all youth who were discharged from BSFT in FY12 and FY13, and matches were identified in their respective databases. Following DJS' recidivism criteria, subsequent involvement with DJS and the adult criminal justice system were combined and categorized as referred to DJS/arrested, adjudicated delinquent/convicted, and committed to DJS/incarcerated (see the insert for definitions). Several cases were missing information necessary for linking data across systems; 79% of FY12 and 84% of FY13 BSFT completers could be matched to DJS data.

As shown in Figure 16, very few of matched youth who completed BSFT in FY12 and FY13 had subsequent referrals to DJS/arrests within one year of discharge (8% for the FY12 cohort, and 12% for the FY13 cohort).[8] And even fewer youth were subsequently adjudicated delinquent/convicted (0% for FY12 and 4% for FY13) and committed to DJS/incarcerated (0% for FY12, 1% for FY13) during the 12 months following discharge.

Juvenile & Criminal Justice System Measures*

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

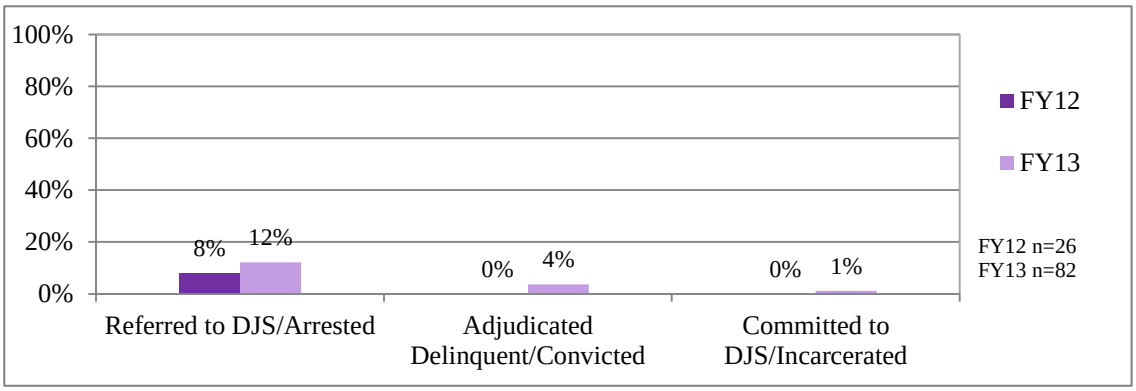
Referred to DJS/Arrested refers to any DJS referral (including all complaints and violations of probation referred to DJS) or adult arrest.

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.*

Figure 16. Juvenile & Criminal Justice System Involvement within 12 Months Post-Discharge, Percent of Youth Who Completed BSFT, FY12-FY13*



*Seven youths in FY12 and 16 youths in FY13 could not be matched to DJS/DPSCS data due to missing identifiers; it is possible that additional youth were involved with DJS/DPSCS.

Table 5 summarizes subsequent involvement with DJS and/or DPSCS within 12 and 24 months for youth who completed BSFT in FY12 and FY13. These numbers suggest that any subsequent justice system involvement was primarily with the juvenile justice system, with only one FY13 completer arrested in the adult system within one year of their BSFT discharge. Within two years of discharge, 15% of youth had been referred to DJS/arrested, but none had subsequently been adjudicated delinquent/convicted and committed to DJS/incarcerated. However, again, not all youth could be matched with the administrative data systems, so additional youth may have been involved with the juvenile or adult criminal justice systems.

[8] Seven youths who completed BSFT in FY12 and 16 youths who completed in FY13 could not be matched to DJS/DPSCS data due to missing identifiers; it is possible that additional youth were involved with DJS/DPSCS.

Table 5. Juvenile & Criminal Justice System Involvement within 12 and 24 Months Post-Discharge, Percent of Youth Who Completed BSFT, FY12-FY13*

		FY12 (n=26)			FY13 (n=82)		
		Ref./ Arrest	Adj./ Convict.	Commit./ Incar.	Ref./ Arrest	Adj./ Convict.	Commit. / Incar.
DJS	12 Months	8%	0%	0%	12%	2%	0%
	24 Months	15%	0%	0%	--	--	--
DPSCS	12 Months	0%	0%	0%	1%	1%	1%
	24 Months	0%	0%	0%	--	--	--
DJS/ DPSCS	12 Months	8%	0%	0%	12%	4%	1%
	24 Months	15%	0%	0%	--	--	--

*Seven youths in FY12 and 16 youths in FY13 could not be matched to DJS/DPSCS data due to missing identifiers; it is possible that additional youth were involved with DJS/DPSCS.

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-BSFT discharge. Of the 84 matched youths who completed BSFT in FY13, only two (2%) youths had some form of new DSS contact within 12 months of discharge—one (1%) youth received new in-home services and one (1%) youth was placed out-of-home (Table 6). Of the 29 matched youth who completed in FY12, only one (3%) youth had a new investigation within 24 months of discharge.

Table 6. Child Welfare System Involvement within 12 and 24 Months Post-Discharge, Percent of Youth Who Completed BSFT, FY12-FY13*

	FY12 (n=29)			FY13 (n=84)		
	Invest-igation	In-Home Service	Out-of-Home Plcmt	Invest-igation	In-Home Service	Out-of-Home Plcmt
12 Months	3%	0%	0%	0%	1%	1%
24 Months	3%	0%	0%	--	--	--

*Four youths in FY12 and 14 youths in FY13 could not be matched to DHR data due to missing identifiers; it is possible that additional youth were involved with DSS.

FY14 BSFT Implementation in Maryland: Successes & Challenges

Utilization

- BSFT was offered in three counties—Baltimore, Carroll, and Prince George's, though the program in Prince George's County closed in June 2014.
- The number of youth who started BSFT dropped substantially from FY13 (n=113) to FY14 (n=79), largely due to one provider's decreased capacity prior to discontinuing BSFT, though decreases were evident for all providers.
- The majority of youth were referred to BSFT by the provider agency or by the parent/family—just 10% were referred by DJS, 6% by schools, and 1% by DSS.
- The global admission length remained the same from FY13 and, on average, youth and families started treatment within three weeks of referral during FY14. There were no significant differences in global admission length by subgroups of youth.
- More than half of the youth who started BSFT in FY14 were male (53%), but the share of female participants increased since FY13. The average age of youth participating in BSFT was 13 years old, and slightly more than half (51%) of the youth were between the ages of 13 and 16 years old. A substantially smaller proportion of African American/Black youth and greater proportion of Caucasian/White youth were admitted in FY14 relative to FY12; this was due, in part, to the decreasing capacity of the Prince George's County program in FY14. Further, very few Hispanic/Latino youth have participated in BSFT, which is notable given BSFT's development with this population of youth and families.
- The majority of youth who started BSFT had no previous involvement with DSS (75%) or DJS (92%). Future analyses should assess additional system and risk/need indicators to better understand the characteristics and needs of youth served.

Fidelity

- The percentage of youth served by certified BSFT therapists in FY14 (83%) remained relatively similar to the previous fiscal year (87%).
- Both the average number of sessions and the average length of stay in BSFT decreased slightly from FY13 to FY14. On average, youth attended 12 sessions over 149 days in FY14, compared to 13 sessions over 153 days in FY13. In FY14, substantial agency/jurisdictional differences were evident in length of stay, but differences were not found with respect to therapist certification.

Outcomes

- Approximately two-thirds (67%) of discharged youth completed treatment in FY14, which represents a decline from the previous fiscal year (85%). Preliminary analyses revealed that there were no significant differences in completion by youth characteristics but that significantly fewer DHFYSC youth completed—likely related to that provider's discontinuation of BSFT services.
- For the third consecutive year, youth who completed BSFT have exceeded Maryland's target of 90% on each of the ultimate outcomes (i.e., living at home, in school/working, and no new arrests at discharge). Further, 94% of completers in FY14 had positive results for all three outcomes.
- Of youth who completed BSFT in FY13, approximately 88% had no DJS referrals/arrests, 96% had no adjudications/convictions, and 99% had no commitments to DJS/incarcerations in the year following treatment completion.

- Only two youths who completed BSFT in FY13 (2%) had new involvement with DSS in the year following discharge.
- Given the low involvement in child-serving system pre-and post-treatment, additional functioning measures should be utilized and analyzed to assess the risks/needs of youth served in BSFT and changes achieved during treatment.

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