Functional Family Therapy in Maryland: FY 2016 Implementation Report

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Executive Summary

Functional Family Therapy (FFT) is an evidence-based practice chosen by Maryland's Children's Cabinet with the goals of providing empirically-supported community-based services that address key youth outcomes and reducing the use of 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 stakeholders. The following report summarizes FFT utilization, fidelity, outcomes, and costs for fiscal year (FY) 2016.

Utilization

- FFT was available in 20 jurisdictions throughout Maryland, with the Department of Juvenile Services (DJS), Children's Cabinet Interagency Fund (CCIF; through a Local Management Board), and Medicaid collectively funding 235 slots. Based on this capacity, Maryland could serve an estimated 705 youths in FFT annually through two providers—Center for Children and VisionQuest.
- Approximately 209 FFT slots were available for treatment on any given day during FY16 (accounting for therapist vacancies) due to both providers experiencing staff turnover.
    - ***Recommendation:*** *Staff turnover has been an ongoing challenge (there was one new therapist per team, 5 total, and 2 new supervisors in FY16). Providers should work with the FFT Implementation Specialist to identify and exercise best practices in staff hiring and retention for FFT.*
- The Statewide utilization of FFT was 70%, and utilization based on actual capacity (available slots) was 79%. Utilization rates have remained stable the past few years, but below the 90% target for the state.
    - ***Recommendation:*** *Referral agencies should continue efforts to improve FFT screening/referral protocols to ensure all appropriate youths and families are identified and referred. Therapist turnover also impacts referrals to the extent that capacity is reduced and agencies are less likely to refer due to waitlists; thus, addressing therapist retention should positively impact utilization. Further, referral agencies should work to support youths and families to engage in treatment. The Institute and the FFT Implementation Specialist will work with referral sources and providers with a goal of ensuring effective protocols/practices are in place that will optimize utilization.*
- Following a reduction in capacity, there was a decrease in referrals to FFT from FY15 (n=866) to FY16 (n=731). Most referrals were made by the DJS (90%), the primary funder of FFT in Maryland.
- The percentage of referred youth who started FFT has remained at 71% or greater since FY14. The primary reasons for not starting FFT in FY16 (n=185) include: *referral/funding source rescinded referral* (28%), *unable to contact family* (21%), and *youth/family/guardian do not consent* (17%).
    - ***Recommendation:*** *The reasons youth do not start FFT have been consistent over time. To address the issue of rescinded referrals, DJS should work to improve screening/referral protocols, ensuring youth are referred to the best service that matches their needs, as opposed to multiple services just to ensure enrollment in one. In cases where FFT in unable to contact the family, referral sources should examine their practices for introducing FFT to the family, ensuring they understand the program and what to expect from the provider. They may want to provide a handout with pertinent information to the family. These strategies may also assist therapists to gain treatment consent from the family.*
- On average, waitlisted youth and families started treatment within 26 weekdays of initial referral during FY16, while non-waitlisted youth and families took an average of 9 weekdays. Global admission lengths (including waitlist time) were significantly longer for youth funded by CCIF and youth who spent time on the waitlist.
    - ***Recommendation:*** *FFT requires therapists to start treatment within 7 days of case assignment. Moving forward, The Institute should monitor days between case assignment and start of treatment specifically. Regardless, efforts should focus on reducing the amount of time to start treatment to*

ensure compliance with model and referral agency expectations. Strategies to support initial family engagement may reduce this length of time, as well as efforts to reduce the use of a waitlist.

- Of the 538 youths who started FFT, the majority was African American/Black (63%) and male (78%), and the average age was 15.9 years old. Most youth (95%) had been involved with DJS and/or DSS prior to starting FFT. Youth with prior DJS involvement (89%) had considerable delinquency histories—on average, these youths had 5 prior complaints filed with DJS. In addition, 45% of youth had prior DSS involvement. Most DJS-involved youth were under probation or aftercare supervision when they started FFT.
    - ***Recommendation:*** *FFT is an appropriate treatment model for use in early stages of juvenile justice case processing. Efforts should be made to identify youth who could benefit from FFT earlier in their DJS involvement and even sooner if the youth and family are involved with DSS.*

Fidelity

- The average *Fidelity* and *Dissemination Adherence* scores exceeded the FFT targets, with *Fidelity* increasing from 3.75 to 3.90 and *Dissemination Adherence* increasing from 4.61 to 4.66 from FY15 to FY16.
- The average length of stay in FFT was 112 days—well within the national purveyor's target of 60 to 180 days.

Outcomes

- 472 youths were discharged from FFT for reasons within the therapist's control in FY16, and **75%** of these youths completed treatment. This is similar to the completion rate from the previous year (74%), and still below the 80% target. FFT expects new sites/therapists to reach 70% completion in their first year. Given the number of new therapists in FY16, a 75% completion rate meets purveyor expectations.
- Of youth who completed FFT in FY16, at the time of discharge: **98%** were living at home, **95%** were in school or working, and **86%** had no new law violations (only the latter outcome missed the 90% target). Further, **82%** achieved success for all three of the outcomes as of discharge.
    - ***Recommendation:*** *Given that most participating youth would be considered high risk for subsequent delinquency, it is expected that some youth will recidivate during treatment. Generally, it is positive that 86% avoided an out-of-home placement and finished FFT.*
- Of youth who completed FFT in FY15, as of one year post-discharge: **61%** did not have a new DJS referral/arrest, **86%** had not been adjudicated delinquent/convicted, and **93%** had not been committed to DJS/ incarcerated for a new offense. Additionally, **86%** had not been placed in residential placement with DJS. These rates are similar to those of previous discharge cohorts. Approximately half of youth who completed FFT in FY13 (51%) and FY14 (47%) were referred to DJS/arrested within two years of discharge.
    - ***Recommendation:*** *Additional analysis shows that youth who recidivated were re-referred to DJS/arrested approximately 4 months after FFT discharge, on average. When relevant, FFT generalization plans should include a subsequent booster session prior to this time frame for high-risk youth. These plans should also be shared with DJS case managers to ensure they can support the youth and family in sustaining positive outcomes.*
- Only **5%** of youth who completed FFT in FY15 had any involvement with the child welfare system within one year of discharge. Based on findings for FY13 and FY14 cohorts, less than 10% of FFT completers had some form of new DSS involvement within two years following discharge.

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 $4,725 per youth.
- The average cost per treatment for FFT was only 10% of the average cost per stay in treatment foster care and 9% of the average cost per stay in therapeutic group homes.

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 for 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 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, on behalf of DJS. This report provides a summary of FFT implementation across the State of Maryland as of fiscal year (FY) 2016. 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 for 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; and reduction of family conflict.

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

Figure 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 2015)*
SAMHSA's National Registry of Evidence-Based Programs & Practices (NREPP) **www.nrepp.samhsa.gov**	Not Listed
Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide **www.ojjdp.gov/mpg**	Effective Program

*Ratings as of March 2017.

FFT Implementation Support

FFT LLC 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 LLC 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 LLC to ensure the most effective implementation of the model.

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 (Figure 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).

[1] All fidelity data are provided by FFT LLC.

Figure 2. FFT Outcome Data—Types and Sources

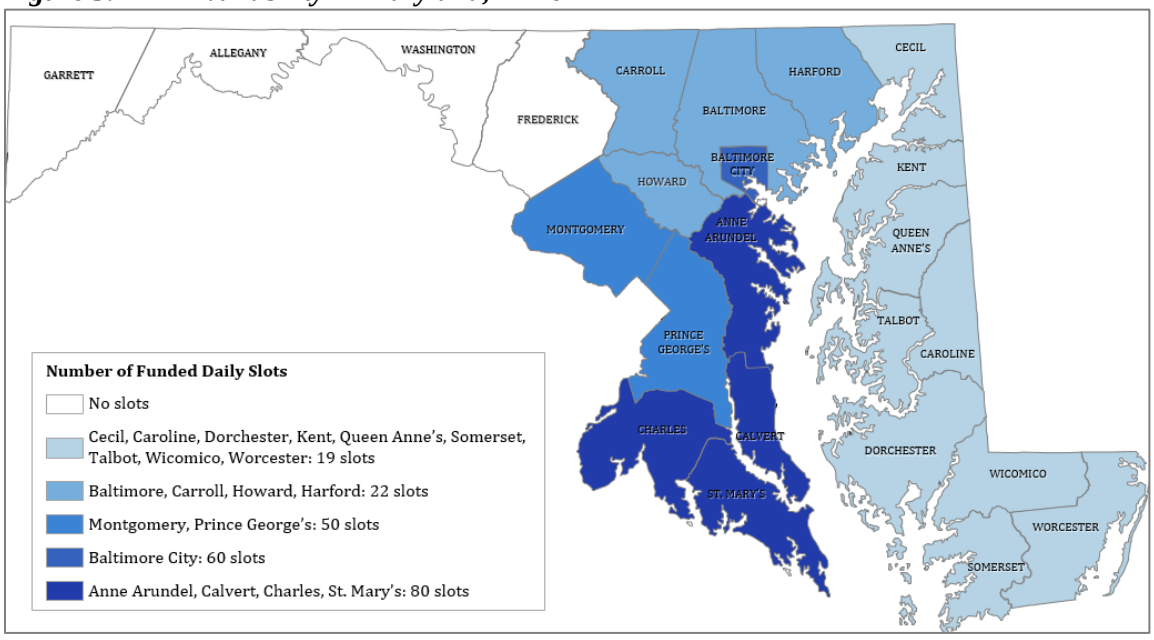
Type	Indicator	Source
Case Progress	➢ Treatment completion ➢ Reason for non-completion (if applicable)	FFT Providers
Ultimate Outcomes at Discharge	➢ Whether the youth was living at home ➢ Whether the youth was in school or working ➢ Whether the youth had any new law violations	FFT Providers
Post-Discharge Outcomes	➢ Involvement in the juvenile and/or criminal justice systems (e.g., DJS referral/arrest, adjudication/ conviction, and DJS 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 FY16. Where possible, data are presented and comparisons are drawn for previous fiscal years. Refer to Appendix 1 for FY16 descriptive data presented by funding source, provider, and jurisdiction.

Where was FFT Offered in Maryland?

In FY16, FFT was offered in 20 jurisdictions[2] in Maryland; it was not available in the western region of the State (Figure 3). FFT was administered by two providers[3] (five FFT teams total)—Center for Children (two teams) and VisionQuest (three teams)—for an estimated annual capacity (based on funding) to serve 705 youths.[4] There was a small reduction in capacity from FY15 due to a reduction in the number of funded slots in Baltimore City. FFT was funded by three sources, including DJS, the Children's Cabinet Interagency Fund (CCIF; via a Local Management Board), and Medicaid. Funding sources and slot allocations varied by jurisdiction (see Figure 4).

Figure 3. FFT Availability in Maryland, FY16



[2] Jurisdictions refer to all Maryland counties and Baltimore City.
[3] Although Baltimore County Bureau of Behavioral Health continued to provide FFT services to youth in Baltimore County, data for this provider are no longer collected by The Institute. This report only includes data from providers who are funded by DJS.
[4] The estimated annual capacity is based on the average number of slots funded by DJS, CCIF, and Medicaid during FY16 (n=235). 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 year.

Figure 4. FFT Service Provision & Funding Sources in Maryland, FY16

Region (DJS)	Jurisdiction(s) Served	Provider	Funding Source	# Funded Daily Slots
Baltimore	Baltimore City	VisionQuest	DJS	60
Central	Baltimore County, Carroll, Howard, Harford	VisionQuest	DJS	22
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-LMB DJS Medicaid	8 72 4

Referrals to FFT

Referral Sources

Following a reduction in capacity from the previous fiscal year (256 slots in FY15 versus 235 in FY16), there was a decrease in the number of referrals to FFT from FY15 (n=866) to FY16 (n=731; Figure 5).

In FY16, most the referrals were made by DJS (90%), followed by the provider agency (7%), and DSS (2%; Figure 6). Nearly two percent (2%) of referrals came from other sources, such as self-referrals from families, hospitals, schools, and other local agencies. DJS has been the principal referral source for FFT in Maryland since FY10.

Figure 5. Number of Referrals to FFT, FY14-FY16

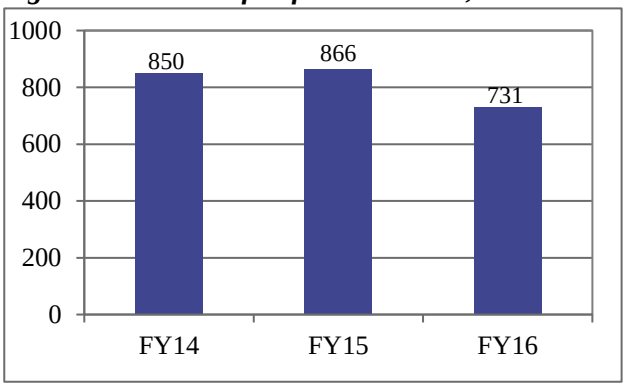
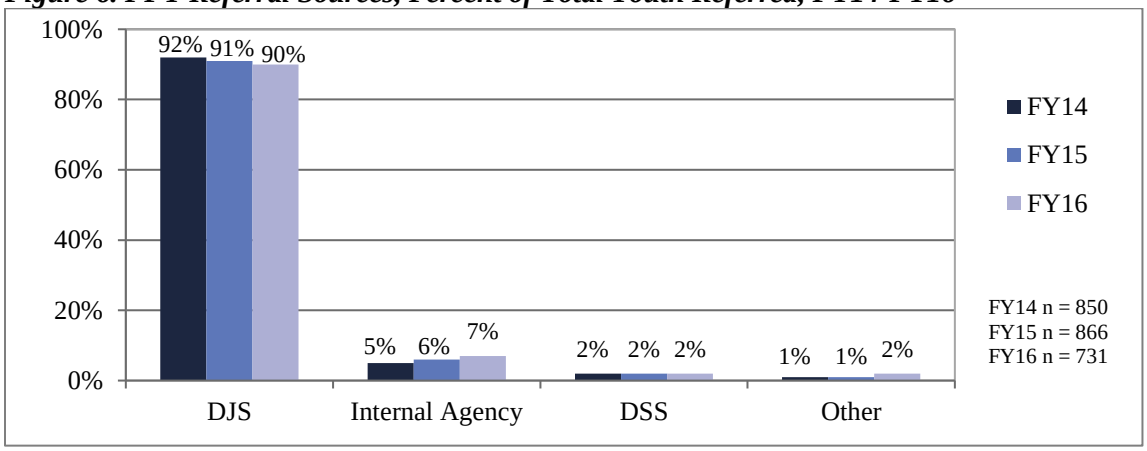


Figure 6. FFT Referral Sources, Percent of Total Youth Referred, FY14-FY16



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 FY16, almost all referred youth met the age criteria for FFT. They tended to be older adolescents—65% were between the ages of 15 and 17 years old (Figure 7), and the average age was 15.9 years old. Sixty-two percent (62%) of referred youth were African American/Black, 27% Caucasian/White, 6% Hispanic/Latino, and 5% another race/ethnicity (Figure 8). Three-quarters (75%) of these youths were male. Characteristics of youth referred to FFT have been generally consistent over the past few years, though a smaller share of referrals were African American/Black youth in FY16.

Figure 7. Ages, Percent of Youth Referred to FFT, FY16

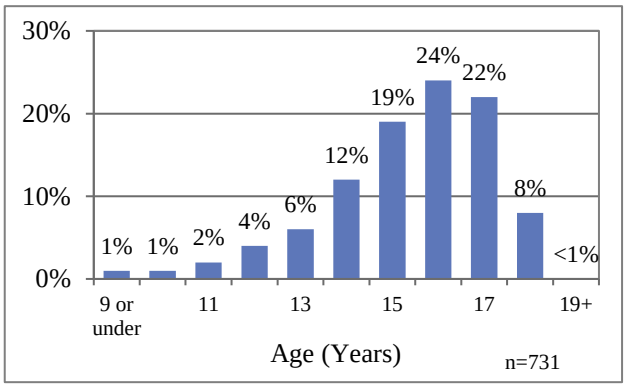


Figure 8. Demographic Characteristics of Youth Referred to FFT, FY14-FY16

	FY14	FY15	FY16
Total Number of Youth	850	866	731
Male	76%	75%	75%
Female	24%	25%	25%
African American/Black	67%	68%	62%
Caucasian/White	23%	22%	27%
Hispanic/Latino	7%	4%	6%
Other	4%	5%	5%
Average Age (s.d.)	16.1 (1.7)	16.0 (1.8)	15.9 (1.8)

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 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, 71% or more of referred youth started FFT (Figure 9). In FY16, over three-quarters (78%) of youth who did not start were eligible for FFT (Figure 10).

Figure 9. Percent of Referred Youth Who Started FFT, FY14-FY16

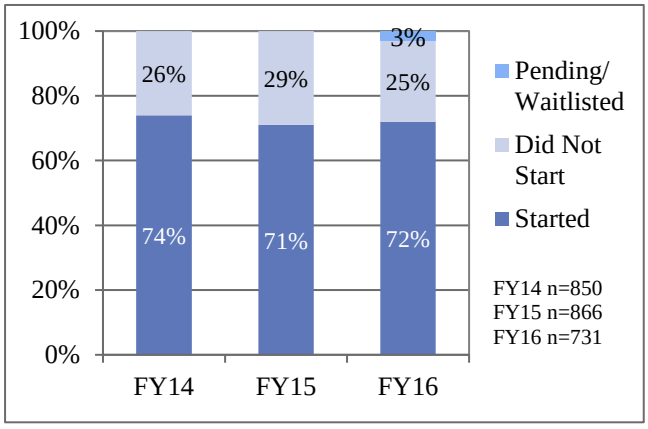
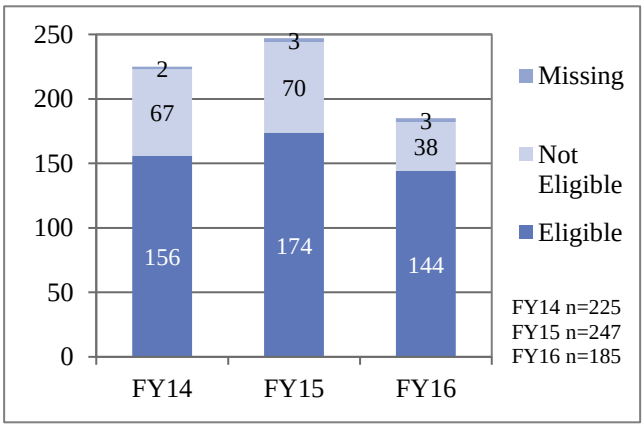


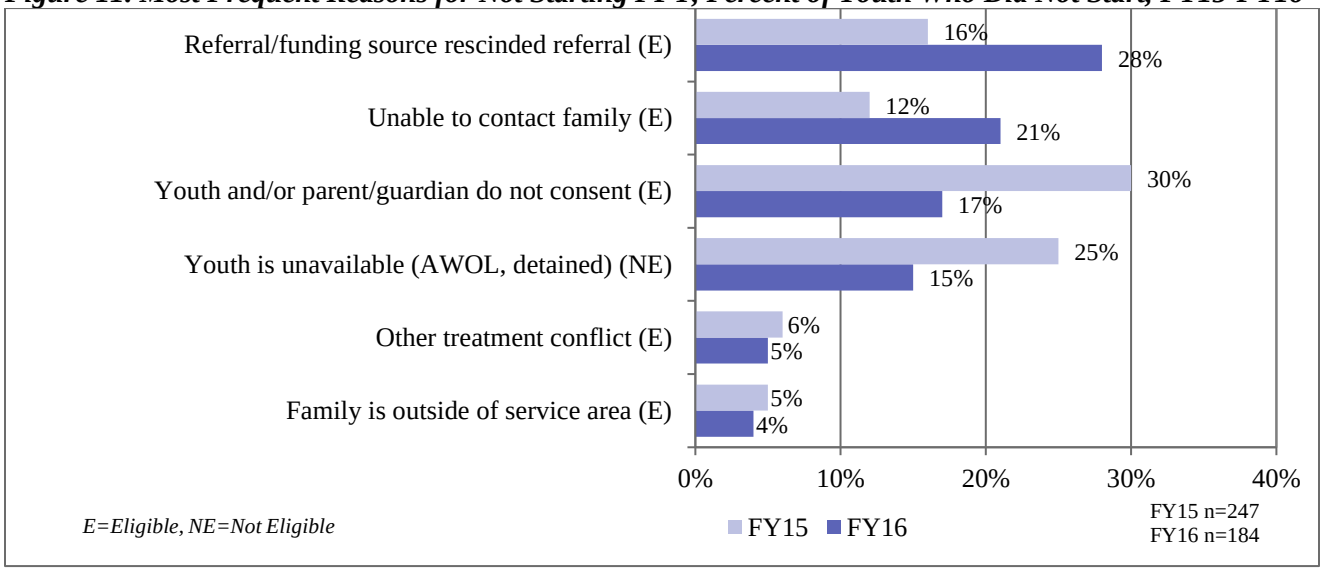
Figure 10. Number of Youth Who Did Not Start FFT by Eligibility, FY14-FY16



The reasons for not starting FFT 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 11 shows the most frequent reasons that youth did not start FFT in FY15 and FY16. In FY16, *referral/funding source rescinded referral* was the most frequently indicated reason, accounting for more than one-quarter (28%) of youth who did not start treatment. In both years, more than one-third of youth did not start treatment due to the *family not consenting* or *unable to contact* (42% in FY15 and 38% in FY16).

Figure 11. Most Frequent Reasons for Not Starting FFT, Percent of Youth Who Did Not Start, FY15-FY16



*The reason for not starting was missing for 3 cases in FY15 and 1 in FY16.

Waitlisted Youth

In FY16, 456 (62%) youths were placed on the waitlist—up from 422 (50%) in FY14 and 519 (60%) in FY15. Consistent with previous fiscal years, slightly less than one-quarter (23%) of youth who were placed on the waitlist did not ultimately start FFT (Figure 12).

Youth can be placed on the waitlist even when the program is not fully utilized due to reductions in available therapists or because the youth/family are not ready to start treatment. Sixty-four percent (64%) of youth were placed on the waitlist in FY16 because the *program was operating at capacity* (Figure 13). An additional 14% were waitlisted *awaiting the youth's release from out-of-home placement*, and 10% were placed on the waitlist due to *staffing shortages*.

Figure 12. Percent of Waitlisted Youth Who Started FFT, FY14-FY16

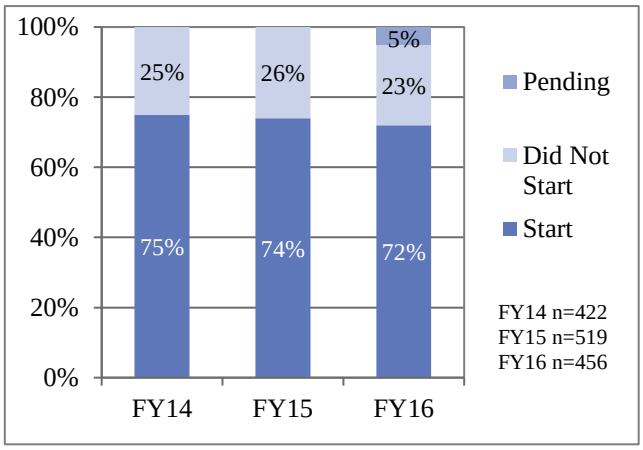
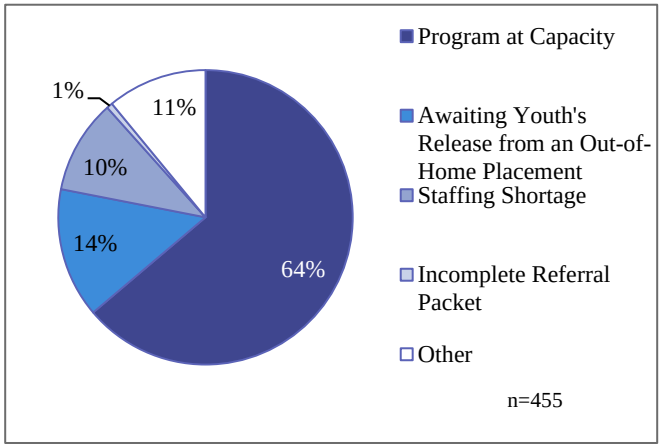


Figure 13. Waitlist Reasons, Percent of Youth Who Were Placed on the Waitlist, FY16*



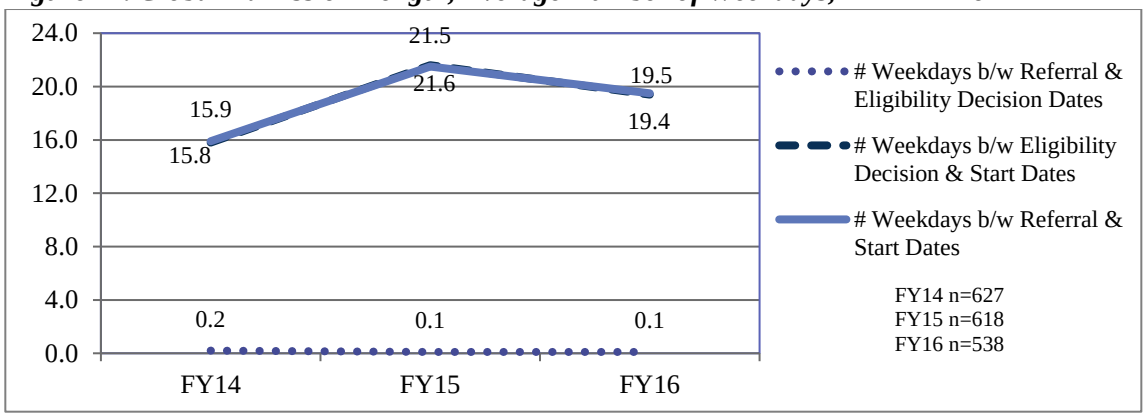
*Waitlist reason was missing for one case in FY16.

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*. In FY16, providers generally made an eligibility decision within one weekday of receiving the referral, and youth typically started treatment within approximately four to five weeks (20 weekdays) of this decision (Figure 14).

Figure 14. Global Admission Length, Average Number of Weekdays, FY14-FY16*



*Six cases were missing eligibility decision dates in FY14 and 5 in FY15.

Among the 538 youths who started FFT in FY16, 346 (64%) were temporarily placed on the waitlist. As shown in Figure 15, waitlisted youth took an average of 26 weekdays to enter treatment, while non-waitlisted youth took an average of nine (9) weekdays. The duration of the admission process decreased for waitlisted youth from the FY15 length.

There were several statistical differences in the global admission length by subgroups of youth, 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 (41.2 days) than youth funded by other sources. Consistent with the previous discussion, those youths placed on the waitlist experienced a significant delay in the start of services compared to non-waitlisted youth.

Figure 15. Global Admission Length by Waitlist Status, Average Number of Weekdays, FY15-FY16

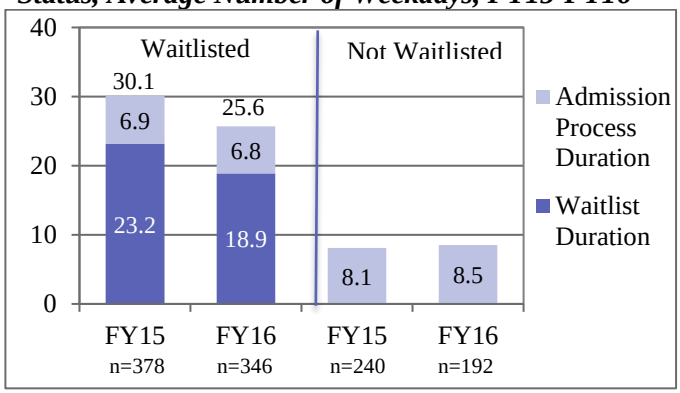
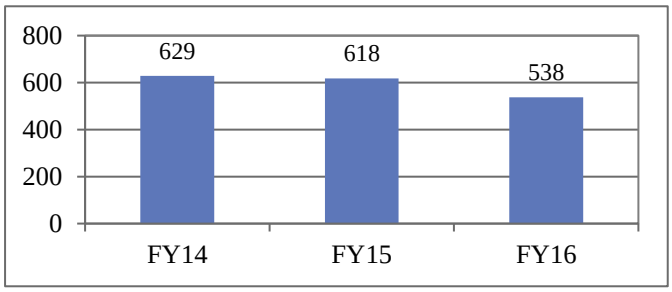


Figure 16. Number of Youth Who Started FFT, FY14-FY16

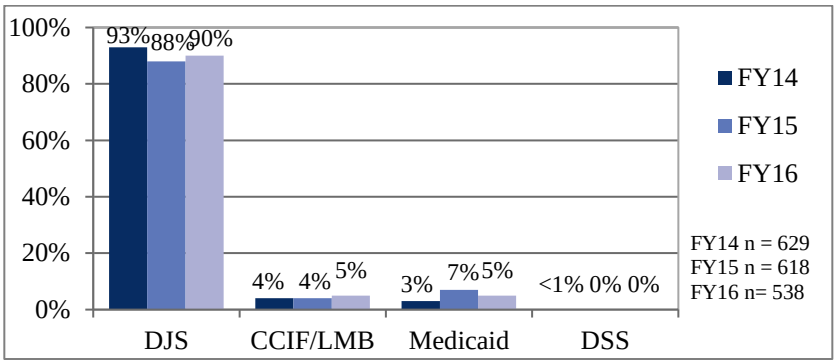


Utilization

A total of 538 youths started FFT in FY16 (Figure 16). This represents a decrease from previous fiscal years. DJS has been the primary funding source for

FFT for the past few years; accordingly, most youth who started FFT in FY16 were funded by DJS (90%), followed by CCIF/LMB (5%) and Medicaid (5%; Figure 17).

Figure 17. FFT Funding Sources, Percent of Youth Who Started, FY14-FY16



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 15 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 a position is vacant). These factors are tracked closely during the year by providers and referral/funding sources to ensure that FFT is reaching as many youth and families as possible.

In FY16, DJS, CCIF, and Medicaid collectively funded a daily capacity of 235 FFT slots across Maryland (Figure 18). On average, 208.7 of these slots were "active", or available to youth and families for treatment. The average daily census of youth served by FFT was 164.7; thus, on average, 70% of funded slots, or 79% of active slots, were utilized. Utilization rates of funded and active slots in FY16 were higher than FY14 and FY15 levels.

Figure 18. FFT Utilization, FY14-FY16

	FY14	FY15	FY16
Avg. Number of Funded Slots	256	256	235
Avg. Number of Active Slots	230.6	208.5	208.7
Avg. Daily Census	177.0	156.5	164.7
Avg. Utilization of Funded Slots	69%	61%	70%
Avg. Utilization of Active Slots	77%	75%	79%

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 FY16 were between the ages of 15 and 17 years old (64%; Figure 19), and their average age was 15.9 years old. The majority of youth were male (78%) and African American/Black (63%; Figure 20). The characteristics of youth who started FFT have remained relatively stable over the past few years.

Figure 19. Ages, Percent of Youth Who Started FFT, FY16

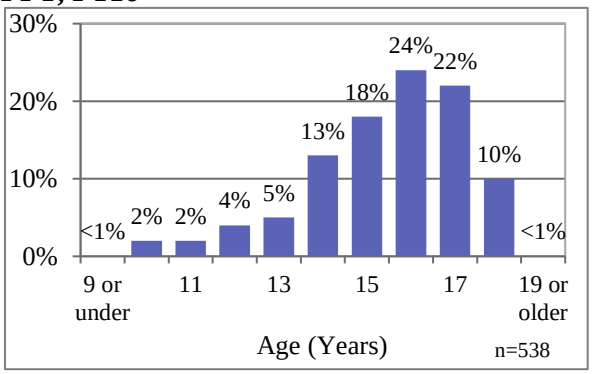
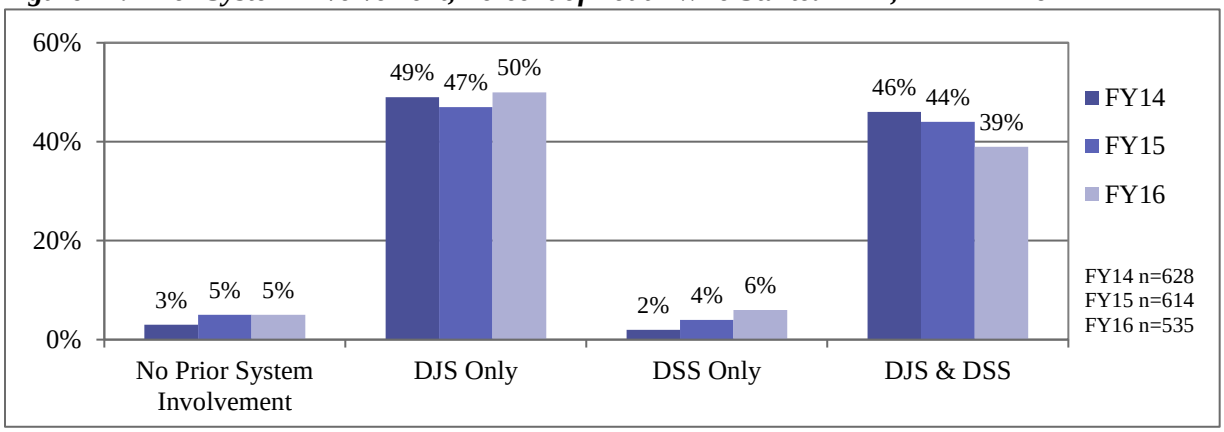


Figure 20. Demographic Characteristics of Youth Who Started FFT, FY14-FY16

	FY14	FY15	FY16
Total Number of Youth	629	618	538
Male	75%	72%	78%
Female	25%	28%	22%
African American/Black	62%	68%	63%
Caucasian/White	25%	22%	25%
Hispanic/Latino	8%	5%	7%
Other	5%	5%	5%
Average Age (s.d.)	16.2 (1.6)	16.0 (1.8)	15.9 (1.8)

The majority (95%) of youth who started FFT in FY16 were currently or previously involved with DJS and/or DSS. Approximately two-fifths (39%) had some form of involvement with both systems (Figure 21)—a slightly smaller share than cohorts of youth who started in FY14 (46%) and FY15 (44%). Half (50%) of youth had prior involvement with DJS only.

Figure 21. Prior System Involvement, Percent of Youth Who Started FFT, FY14-FY16*



*Some youth could not be matched to DHR data (1 case in FY14, 4 in FY15, and 3 in FY16); it is possible the additional youths were involved with DJS and/or DSS.

Involvement with the Juvenile Justice System

To describe youth's previous involvement with DJS, cases were matched with DJS's administrative data. In FY16, 89% of youth had at least one prior complaint filed with DJS (Figure 22). Of those with previous DJS involvement, youth had, on average, five prior DJS complaints, and their average age at first complaint was 13.8 years old. Just under one-third (31%) of youth had at least one prior committed residential placement with DJS, and this subset of youth averaged two prior placements.

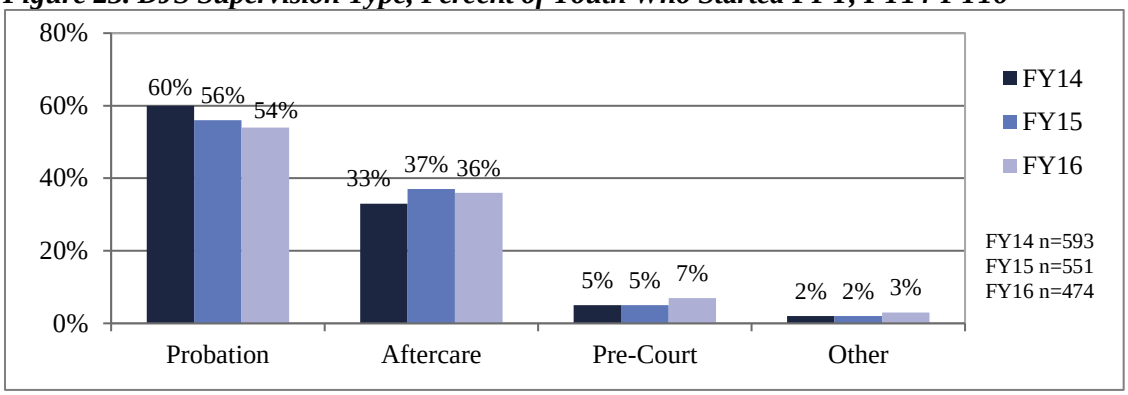
Figure 22. Prior DJS Involvement, Percent of Youth Who Started FFT, FY14-FY16

	FY14	FY15	FY16
Total Number of Youth	629	618	538
Any Prior DJS Complaints	95%	91%	89%
Avg. # of Prior DJS Complaints (s.d.)	4.7 (3.7)	5.0 (3.6)	4.9 (4.2)
Avg. Age at First DJS Complaint (s.d.)	13.9 (1.9)	13.7 (2.0)	13.8 (2.1)
Any Prior DJS Committed Residential Placements	28%	29%	31%
Avg. # of Prior DJS Committed Residential Placements (s.d)	1.8 (1.2)	1.8 (1.1)	2.0 (1.3)

Eighty-eight percent (88%) of youth were actively involved with DJS when they started FFT—a slight decrease from prior fiscal years (94% in FY14; 89% in FY15). The type of DJS involvement/supervision has changed slightly over time, though most youth have been under probation or aftercare supervision (Figure 23). In the most recent reporting year, 54% of DJS-involved youth were under probation, 36% aftercare (i.e., committed to DJS), 7% pre-court, and 3% other supervision.[5] Of youth under probation or aftercare supervision, 17% 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, 94 youths (22% of youth under aftercare or probation supervision) had been released from a committed residential placement within 30 days of starting FFT.

[5] Pre-court supervision occurs at intake when a youth and his/her family enter 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 youths are usually transitioned into probation or aftercare supervision.

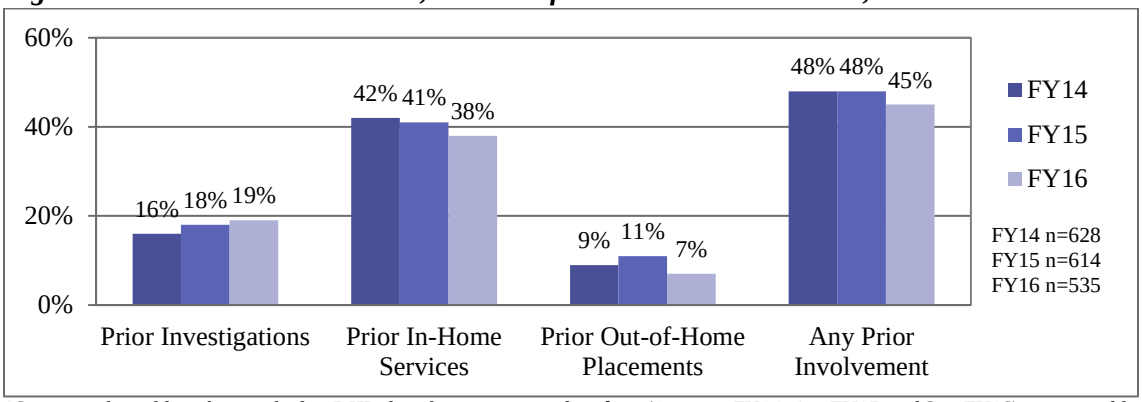
Figure 23. DJS Supervision Type, Percent of Youth Who Started FFT, FY14-FY16



Involvement with the Child Welfare System

Youth were also matched with DHR's SACWIS (State Automated Child Welfare Information System) system to describe their previous experiences with DSS. Of youth who started FFT in FY16, 45% had some form of prior contact with the child welfare system—a slight decrease from previous cohorts (Figure 24). Prior to being referred to FFT, 19% of youth were part of a prior DSS investigation,[6] 38% had received in-home services, and 7% had been placed out of home. On average, youth were 8.0 years old at the time of their first in-home service and 6.6 years old at the time of their first out-of-home placement.

Figure 24. Prior DSS Involvement, Percent of Youth Who Started FFT, FY14-FY16*



*Some youth could not be matched to DHR data due to missing identifiers (1 case in FY14, 4 in FY15, and 3 in FY16); it is possible the 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 25). Notably, males and youth with no prior DSS involvement were more likely to start FFT in FY16, relative to their counterparts. Rates of starting FFT also varied substantially by jurisdiction; these figures can be found in Appendix 1.

Figure 25. Factors Related to Starting FFT in FY16

Characteristics of youth who were <u>more likely</u> to start:

- ✓ Male
- ✓ <u>No</u> prior DSS involvement

Not statistically related to starting FFT:

- x Age
- x Race/Ethnicity
- x Prior DJS complaints
- x Prior DJS committed residential placements
- x Waitlisted
- x Funding source

[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.

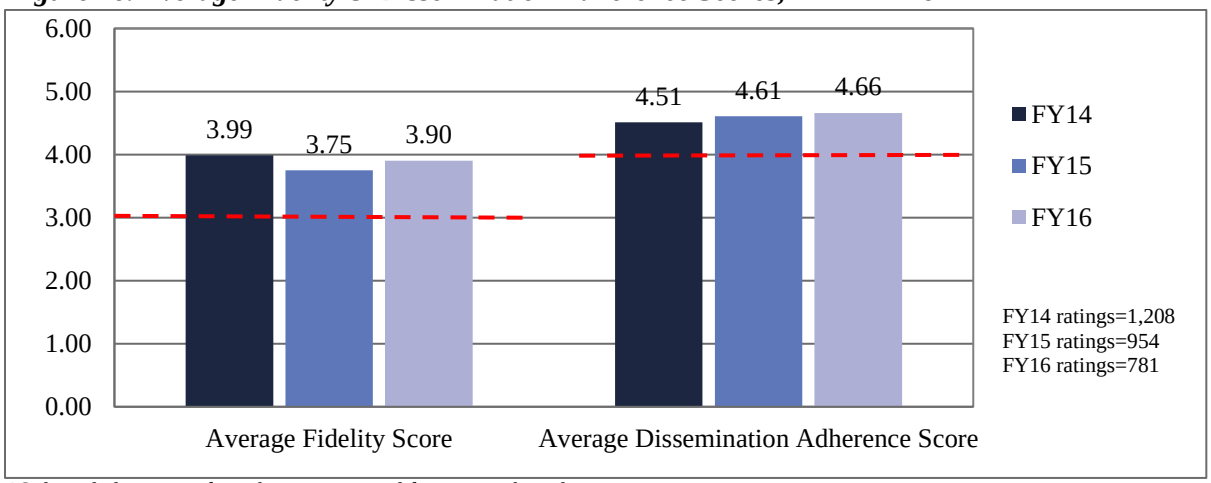
FFT Model Fidelity

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 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 3.0.
- 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 4.0.

Figure 26 illustrates the *Average Fidelity* and *Average Dissemination Adherence Scores* for all FFT teams in Maryland between FY14 and FY16. Both scores increased slightly from FY15 to FY16—the *fidelity* score increased from 3.75 to 3.90 and the *average dissemination* score increased from 4.61 to 4.66. Overall, the teams continue to surpass the target scores.

Figure 26. Average Fidelity & Dissemination Adherence Scores, FY14-FY16*



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

FFT Discharges & Outcomes

Of the 550 youths who were discharged from FFT in FY16, 472 (86%) were discharged for reasons *within therapist control*.[7] The remaining 14% of cases were discharged for reasons *outside of therapist control* (note that these cases will not be included in subsequent analyses).[8]

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

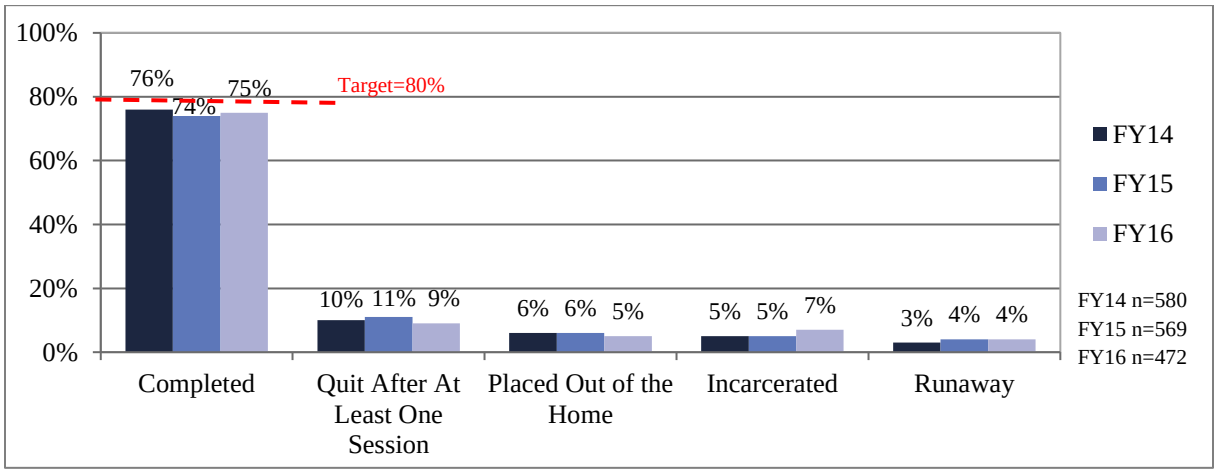
1) Did the youth and his/her family complete treatment (i.e., case progress)?
2) Were there sufficient changes in factors associated with problem behaviors (i.e., outcome type)?[9]
3) How was the youth doing in three primary areas of functioning at discharge (i.e., ultimate outcomes)?

Each of these questions are addressed separately in this section.

Case Progress at Discharge

Most youth *completed* FFT in FY16 (75%; Figure 27). Though this outcome has remained stable for the past three fiscal years (76% in FY14 and 74% in FY15), it still falls slightly below the national purveyor's 80% target. Of the remaining cases discharged within therapist control, 9% *quit after at least one session*, 7% were *incarcerated*, 5% of youth were *placed out of the home*,[10] and 4% *ran away*.

Figure 27. Discharge Reasons, Percent of Youth Discharged within Therapist Control from FFT, FY14-FY16*



*In addition, one youth deceased in FY16.

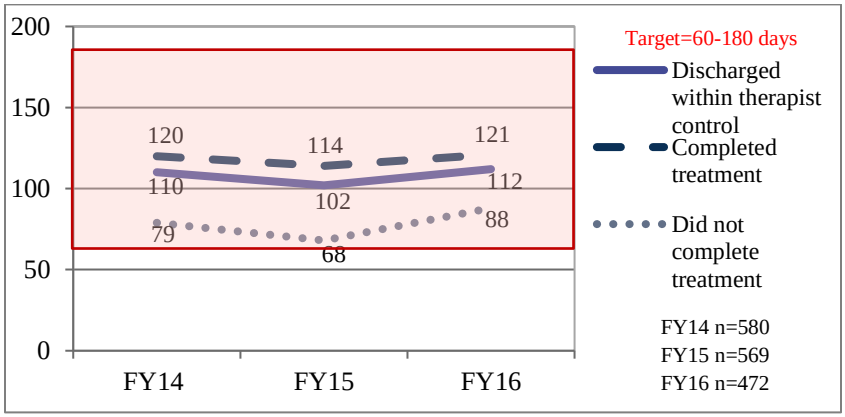
Bivariate analyses indicate that Caucasian/White youth (81%) and youth categorized as Hispanic/Latino (91%) and Other (78%) were significantly more likely to complete FFT than were African American/Black youth (72%) in FY16. In addition, youth who were younger, had no prior child welfare involvement, and had no prior commitment to a residential DJS placement were significantly more likely to complete treatment than their respective counterparts. Youth who were waitlisted were also significantly more likely to complete FFT. There were also substantial variations by provider agency and jurisdiction (see Appendix 1).

[7] Discharge reasons for youth classified as *within therapist control* include: completed case, quit after at least one session, runaway, placed out of home, incarcerated, and youth deceased.
[8] Discharge reasons for youth classified as *outside of therapist control* include: moved prior to completing the program, administrative reasons, and youth referred to other services. Of the 77 youths who were discharged outside of therapist control in FY16, 53 discharged due to administrative reasons, 16 moved, and 8 were referred to other services (one missing).
[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] Out-of-home placements include, but are not limited to, substance abuse inpatient programs, group homes, or therapeutic group homes.

Length of Stay

The average length of stay (ALOS) in FFT treatment was 112 days, meeting the national purveyor's target of 60-180 days (Figure 28). The ALOS was substantially longer for youth who completed treatment (121 days) as compared with those who did not complete (88 days). FFT completers had an average of 12 sessions, whereas those who did not complete had 5 sessions, on average.

Figure 28. Length of Stay in FFT, Average Number of Days, FY14-FY16



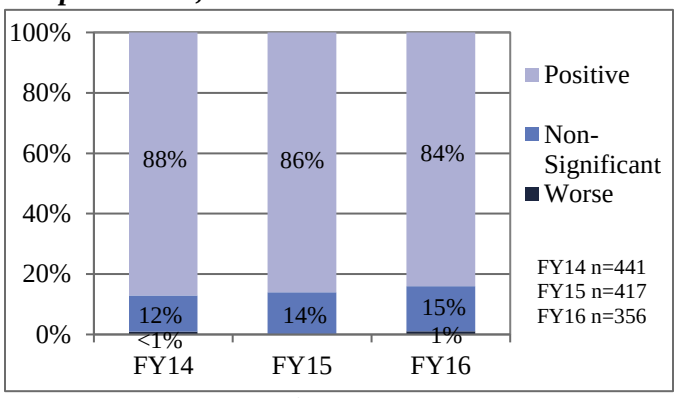
Length of stay in FFT was related to certain youth characteristics in FY16. Specifically, of those discharged within therapist control, youth who were previously placed in a DJS committed residential placement and those with no prior DSS involvement had significantly shorter lengths of stay. Age, gender, race/ethnicity, having a prior DJS referral, and funding source were not statistically related to length of stay. Differences in lengths of stay by agency and jurisdiction are provided in Appendix 1.

Change in Risk and Protective Factors at Discharge

Even though most youth completed FFT, the program's level of effectiveness could vary across youth. Upon completion, family members and therapists complete standardized assessments of the family's change in risk and protective factors. The *Outcome Type* is a composite measure of the family and therapist assessments. A positive outcome indicates that family members and the therapist consistently rated the family as having significantly diminished risk factors and/or strengthened protective factors during the course of treatment. A worse outcome indicates that risk factors increased and/or protective factors diminished, and a non-significant outcome reflects little to no change.

A majority of youth who completed FFT in FY16 showed a positive outcome at discharge (84%). Fifteen percent (15%) demonstrated no significant change, and only 1% experienced a worse outcome. Outcomes remained consistent over the past three fiscal years (Figure 29).

Figure 29. Outcome Type, Percent of Youth Who Completed FFT, FY14-FY16*



*Outcome type was not available for 5 youths who completed in FY15.

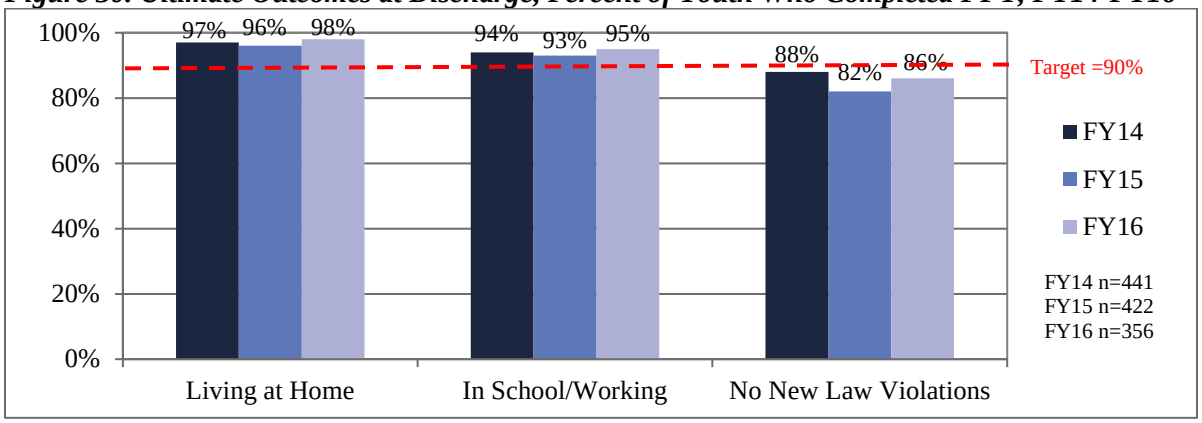
Ultimate Outcomes at Discharge

Providers report on three additional indicators of success at discharge, referred to as the *ultimate outcomes;* these include: (1) whether the youth was living at home, (2) whether the youth was in school and/or working, and (3) whether the youth had a new law violation since treatment had started. Other measures of success include post-discharge outcomes, which are discussed in the next section.

Figure 30 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 for two of the three outcomes – *living*

at home and *in school and/or working* – in each of the three years. Further, 82% of completers in FY16 had positive results for all three outcomes.

Figure 30. Ultimate Outcomes at Discharge, Percent of Youth Who Completed FFT, FY14-FY16*



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). Whereas the ultimate outcomes indicate that 14% of completers had new arrests during treatment, data provided by DJS and DPSCS[11] indicate that 16% of completers had been referred to DJS/arrested for a felony or misdemeanor offense while receiving FFT in FY16. In addition, DJS data show that 8% 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. To assess these outcomes post discharge, The Institute provided DJS and DPSCS with the name, gender, race/ethnicity, and date of birth of *all* youths who were discharged from FFT in FY13, FY14, and FY15, 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 (5 youths in FY13, 8 in FY14, and 4 in FY15).[12]

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 or adult arrest for a misdemeanor or felony offense.

Adjudicated Delinquent/Convicted refers to any felony/ misdemeanor complaint that is adjudicated delinquent at a judiciary hearing or any adult arrest that results in a guilty finding at a criminal court hearing.

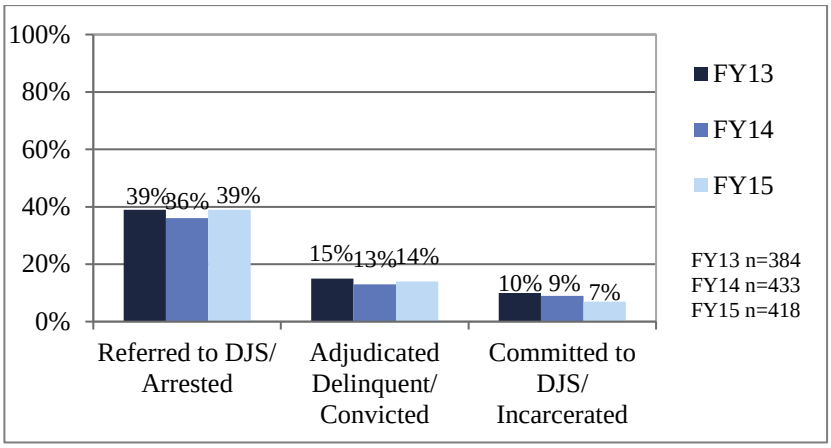
Committed to DJS/Incarcerated refers to any commitment to DJS custody as a result of a felony/misdemeanor complaint that is adjudicated delinquent, as well as incarceration in the adult system that results from an adult arrest and conviction.

These measures exclude recidivism events outside of Maryland.

[11] Criminal justice system data were only obtained for DJS-referred or DJS-funded youths, which are most youths who completed FFT.
[12] 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.

Of youth who completed FFT in FY15, 39% were subsequently referred to DJS or arrested within one year of discharge (compared with 39% for FY13 and 36% for FY14; Figure 31). Smaller shares of youth were ultimately adjudicated delinquent/convicted (14% in FY15) and committed to DJS/incarcerated for these arrests (7% in FY15). Recidivism rates have remained relatively stable across the past three discharge cohorts.

Figure 31. Juvenile & Criminal Justice System Involvement within 12 Months Post Discharge, Percent of Youth Who Completed FFT, FY13-FY15*



*Excludes youth placed in secure DJS facilities as of FFT discharge. Criminal justice system data were only obtained for DJS-referred or DJS-funded youths, which are most youths who completed FFT.

According to bivariate analyses using all FFT completers from FY13 through FY15, youth who were younger at admission, African American/Black, male, had a prior DJS referral, and had prior DSS involvement were significantly more likely to be referred to DJS/arrested within one year following FFT discharge, relative to their counterparts. In addition, having a longer length of stay was associated with greater risk of referral to DJS/arrest within one year post-discharge. Substantial differences were also evident by agency and jurisdiction (Appendix 1).

Figure 32 summarizes subsequent involvement with DJS and/or DPSCS within 12 and 24 months for youth who completed FFT in FY13, FY14, and FY15. These numbers suggest that justice system involvement was driven primarily by contacts with the juvenile justice system, though 23% of FY13 completers and 18% of FY14 completers were arrested in the adult system within two years of discharge. Overall, 19% of the youth who completed FFT in FY14 had been adjudicated delinquent/convicted within 24 months of discharge, and 11% were subsequently committed to DJS/incarcerated.

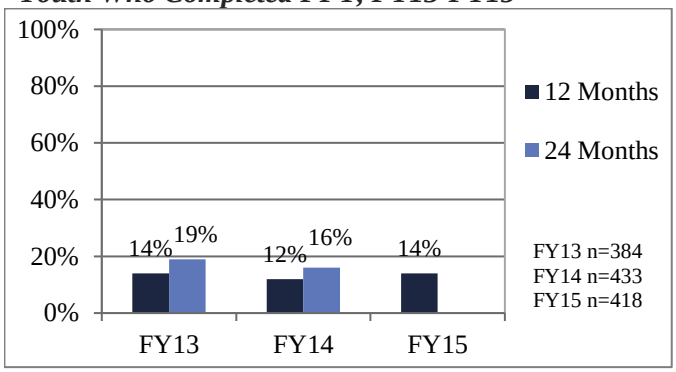
Figure 32. Juvenile & Criminal Justice System Involvement within 12 and 24 Months Post Discharge, Percent of Youth Who Completed FFT, FY13-FY15*

		FY13 (n=384)			FY14 (n=433)			FY15 (n=418)		
		Ref./ Arrest	Adj./ Convict.	Comm./ Incar.	Ref./ Arrest	Adj./ Convict.	Comm./ Incar.	Ref./ Arrest	Adj./ Convict.	Comm./ Incar.
DJS	12 Months	28%	11%	5%	28%	10%	6%	33%	12%	5%
	24 Months	34%	14%	7%	34%	14%	7%	--	--	--
DPSCS	12 Months	14%	5%	5%	10%	3%	3%	8%	3%	2%
	24 Months	23%	11%	11%	18%	6%	5%	--	--	--
DJS/ DPSCS	12 Months	39%	15%	10%	36%	13%	9%	39%	14%	7%
	24 Months	51%	23%	17%	47%	19%	11%	--	--	--

*Excludes youth placed in secure DJS facilities as of FFT discharge. Criminal justice system data were only obtained for DJS-referred or DJS-funded youths, which are most youths who completed FFT.

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 to be placed in a residential facility.[13] Consequently, more youth may be admitted to a residential placement following discharge from FFT than indicated by rates of commitment (shown above). Fourteen percent (14%) of youth who completed FFT in FY15, as well as 14% in FY13 and 12% in FY14, were admitted to a residential placement by DJS during the 12 months following discharge (Figure 33). When the follow-up period is extended to 24 months, the majority of youth still avoided post-discharge residential placement admissions; 19% of the youth who completed in FY13 and 16% of the youth who completed in FY14 were admitted to a committed residential placement by DJS within 24 months of discharge from FFT.[14]

Figure 33. DJS Committed Residential Placement within 12 and 24 Months Post Discharge, Percent of Youth Who Completed FFT, FY13-FY15*



*Excludes youth placed in secure DJS facilities as of FFT discharge.

Subsequent Involvement with the Child Welfare System

The Institute also provided DHR with the names, dates of birth, and other demographic variables of all youths who were discharged prior to the last day of FY15 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 442 youths who completed FFT in FY15, 5% had some form of new DSS involvement within 12 months of discharge (Figure 34)—1% had a new DSS investigation, 3% received in-home services, and 1% were placed out of home (Figure 35). Of FFT completers in FY13 and FY14, 7% and 8%, respectively, had some form of new DSS involvement within 24 months of discharge.

Figure 34. New Child Welfare Involvement within 12 and 24 Months Post Discharge, Percent of Youth Who Completed FFT, FY13-FY15

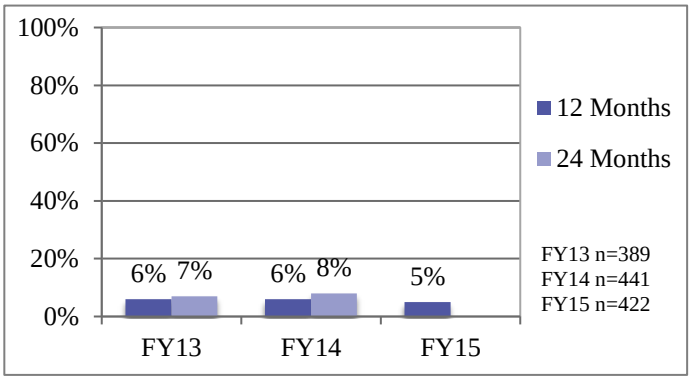


Figure 35. Child Welfare System Involvement within 12 and 24 Months Post Discharge, Percent of Youth Who Completed FFT, FY13-FY15

	FY13 (n=389)			FY14 (n=441)			FY15 (n=422)		
	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	1%	4%	2%	1%	5%	1%	1%	3%	1%
24 Months	1%	5%	2%	2%	6%	1%	--	--	--

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

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

Cost of FFT in Maryland

In FY16, the total service delivery cost for providing FFT in Maryland was $2,598,991. This amount includes payments made to service providers—either through contracts with funders or through Medicaid reimbursements—as well as the amount contracted through The Institute to provide training, coaching, and fidelity monitoring. Although there were variations in costs across the different providers, on average, the cost of administering FFT was $4,725 per discharged youth (Figure 36).

Figure 36. Service Delivery Cost of FFT in Maryland, FY16

Number of Discharged Youths	550
Avg. Service Delivery Cost per Youth	$4,725
Total Service Delivery Cost	$2,598,991

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 (e.g., DJS, Medicaid, and CCIF), most are funded by DJS; thus, a simple analysis was conducted for DJS-funded youth to compare costs of FFT with those of residential programs that serve comparable youth. The costs presented in this section are calculated as per diem rates and based solely on the contracted amounts between service providers and DJS, thereby excluding costs associated with training, coaching, and implementation data monitoring. The total estimated cost of care is based on these per diem rates multiplied by the average length of stay for each program—both important factors in overall costs. Findings are presented as averages by program type in Figure 37.

Figure 37. Cost Analysis of FFT and Placements for DJS-Funded Youth, FY16*

Program Type	Average Per Diem Rate	Average Length of Stay (Days)	Avg. Cost per Stay/ Treatment
FFT	$43	107	$4,551
Treatment Foster Care	$164	308	$47,015
Group Home	$216	210	$45,708
Therapeutic Group Home	$259	193	$50,060

*Per Diem Rate and Average Length of Stay were provided by DJS. The Average Cost per Stay/Treatment was calculated by multiplying the Per Diem Rate by the Average Length of Stay for each program. The numbers presented in this table represent averages for each program type.

Within the DJS residential service array, treatment foster care programs, group homes, and therapeutic group homes serve youth who are most similar to the profiles of youth served by FFT, and data for these programs are presented accordingly. In FY16, the average per diem rates were $164 for treatment foster care programs, $216 for group homes, and $259 for therapeutic group homes. At the same time, the average FFT per diem rate for DJS youth was considerably lower at $43. Further, FFT had a shorter average length of stay relative to the residential programs. A comparison of total costs across program types shows that FFT has the potential to result in substantial cost savings. For example, the FFT cost for DJS youth was 9% of the cost per stay in therapeutic group homes and 10% the cost per stay in treatment foster care programs. This analysis should be considered with caution, however, for several key reasons. For one, this analysis does not identify comparable youth across programs (e.g., it is possible that some of the residential programs serve higher risk youth and/or those who would not be eligible for FFT). Also, the per diem rates and lengths of stay vary considerably within each program type and total costs may significantly lower or higher depending on the program—an average was presented merely to simplify the analysis. Third, as stated above, costs included in these calculations do not necessarily account for all costs required to operate these programs. Finally, a more comprehensive analysis would consider both positive and negative program outcomes, and their associated monetary benefits and costs. Notwithstanding, this analysis suggests that FFT is significantly less costly than residential care for youth.

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