Functional Family Therapy in Maryland: FY 2015 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 providers and stakeholders. The following report summarizes FFT utilization, fidelity, outcomes, and costs across the State for fiscal year (FY) 2015.

Utilization

- FFT was available in 20 jurisdictions throughout Maryland. Based on FY15 funding capacity, Maryland could serve an estimated 903 youths in FFT annually.
- The Statewide utilization of FFT was 67%, and utilization based on actual capacity (available slots) was 80%. Utilization rates have remained stable the past few years, but below the 90% target for the state.
    - ***Recommendation:*** *In FY15, efforts were made to address utilization through better screening practices. Increased discussion in this area has created an interest and examination of the screening practices that do exist. This is an ongoing area of focus.*
- 1,057 youths were referred to FFT in FY15—a slight increase from the previous fiscal year. The majority of referrals were provided by the Department of Juvenile Services (DJS; 75%).
- The percentage of referred youth who started FFT has remained at 67% or greater since FY13. Almost half of the 341 youths who did not start FFT in FY15 was due to difficulty contacting the family or gaining consent for treatment.
    - ***Recommendation:*** *FFT providers and referral sources should continue their collaborative efforts to devise creative strategies to connect families and FFT therapists. For example, DJS case managers have invited FFT therapists to meetings at the DJS field office so therapists can introduce themselves and the program to families. This also assists in obtaining consent for treatment. Referral sources should also continue to focus on better program education for parents. This may be best achieved through training for referral sources, along with materials that can be used with families. Referral sources should also ensure that contact information on FFT referral forms is accurate and complete.*
- The global admission length has increased from previous fiscal years, and, on average, youth and families started treatment within 22 weekdays of referral to FFT during FY15. Global admission lengths were significantly longer for youth funded by the Children's Cabinet Interagency Fund (CCIF) and youth who spent time on the waitlist. Seventy percent (70%) of youth were placed on the waitlist in FY15 because the *program was operating at capacity*, 19% due to *staffing shortages*, and 5% were *awaiting the youth's release from out-of-home placement*.
    - ***Recommendation:*** *High utilization and programs at capacity would suggest the need to expand. However, staff turnover contributed to some of the lower capacity percentage, hence the lower utilization averages with programs at capacity. For programs that have a waitlist but no staffing shortage, there may be a need to expand. This will be examined more closely.*
- The majority of youth who started FFT were African American/Black (66%) and male (70%), and the average age was 15.8 years old. Most youth were involved with DJS upon starting FFT (79%), and these youths had considerable delinquency histories—on average, youth had five prior complaints filed with DJS. In addition, 49% of youth had prior involvement with the child welfare system.

- ***Recommendation:*** *FFT in Maryland tends to be targeted for youth in the deep end of the juvenile justice system; however, the program can work with youth before they reach this level of system involvement. Discussions regarding referring youth earlier have begun.*

Fidelity

- The *Average Fidelity Score* and the *Average Dissemination Adherence Score* both exceeded the FFT national target, with *Fidelity* decreasing from 3.99 to 3.75 and *Dissemination Adherence* increasing from 4.51 to 4.61 from FY14 to FY15.
- The average length of stay in FFT was 111 days—well within the national purveyor's target of 60 to 180 days.

Outcomes

- 662 youths were discharged from FFT within the therapist's control in FY15, and **76%** of these youths had completed treatment, similar to the completion rate from the previous year. Males were significantly less likely to complete treatment. DJS- and Medicaid-funded youth (74% and 69%, respectively) were also significantly less likely to complete treatment compared with youth funded by DSS (86%) and CCIF (86%).
    - ***Recommendation:*** *With a few new therapists providing FFT, a completion rate slightly lower than 80% is not unexpected and should improve as they gain more experience. The rate should just be monitored moving forward.*
- Of youth who completed FFT in FY15, at the time of discharge: **96%** were living at home, **94%** were in school or working, and **84%** had no new law violations (only the latter outcome missed the 90% target). Further, **78%** achieved success for <u>all</u> three of the outcomes as of discharge.
    - ***Recommendation:*** *It is important to consider that those youths who did receive new law violations were still able to complete treatment and not be placed outside the home or community. However, FFT Site Supervisors should review cases for potential reoffending behavior.*
- Of youth who completed FFT in FY14, as of one year post-discharge: **66%** did <u>not</u> have a new DJS referral/arrest, **88%** had <u>not</u> been adjudicated delinquent/convicted, and **93%** had <u>not</u> been committed/incarcerated. Additionally, **89%** had <u>not</u> been placed into a committed residential placement with DJS. There was a decrease in all justice system contact percentages for youth who completed FFT in FY14 compared to those for the FY13 cohort.
- Only **6%** of youth who completed FFT in FY14 had any involvement with the child welfare system within one year of discharge. Based on findings for FY12 and FY13 cohorts, less than 10% of FFT completers had some form of new DSS contact 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 $4,554 per youth.
- The average cost per treatment for FFT was only 7% of the average cost per stay in treatment foster care and 8% 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. This report provides a summary of FFT implementation across the State of Maryland as of fiscal year (FY) 2015. 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 pre-treatment 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.

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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 Outcomes Data—Types and Sources

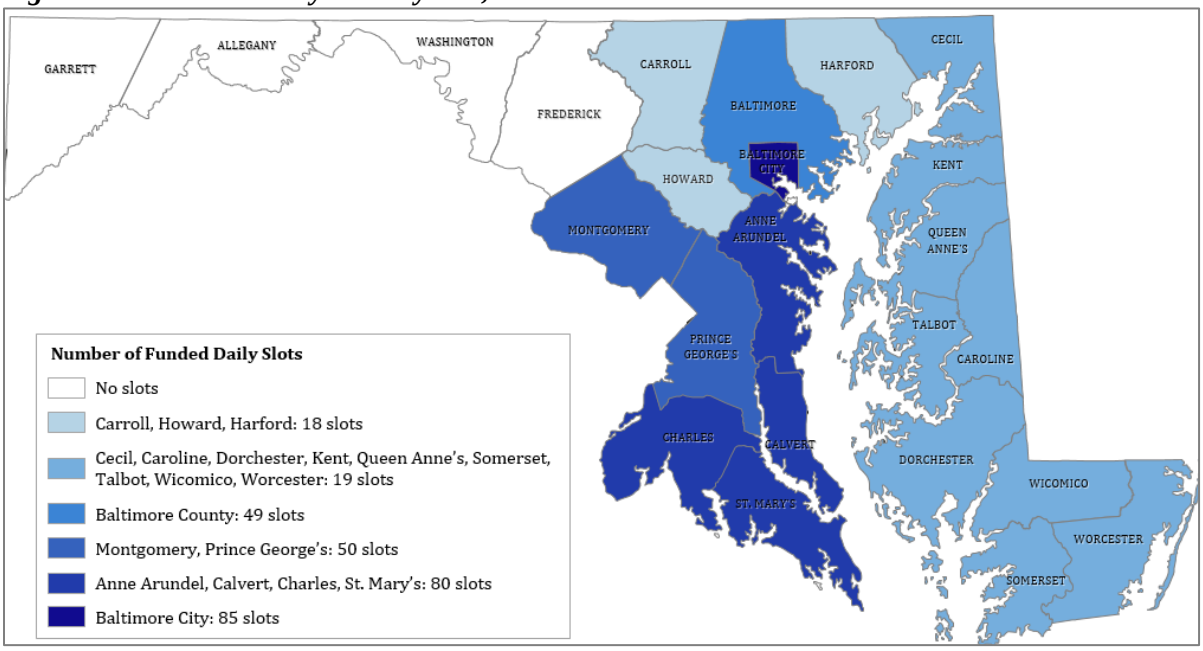
Type	Indicator	Source
Case Progress	➢ Treatment completion ➢ Reason for non-completion (if applicable)	FFT Providers
Ultimate Outcomes at Discharge	➢ Whether the youth was living at home ➢ Whether the youth was in school or working ➢ Whether the youth had any new law violations	FFT Providers
Post-Discharge 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 FY15. Where possible, data are presented and comparisons are drawn for previous fiscal years. Appendix 1 shows FY15 descriptive data presented by funding source, provider, and jurisdiction.

Where was FFT Offered in Maryland?

In FY15, 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 three providers (seven FFT teams total)—Baltimore County Bureau of Behavioral Health (two teams), Center for Children (two teams), and VisionQuest (three teams)—for an estimated annual capacity (based on funding) to serve 903 youths.[3] There was just a small reduction in capacity from FY14. FFT was funded by four sources, including DJS, the Children's Cabinet Interagency Fund (CCIF, via Local Management Boards), a local Department of Social Services (DSS), and Medicaid. Funding sources and slot allocations varied by jurisdiction (see Figure 4).

Figure 3. FFT Availability in Maryland, FY15



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

[3] The estimated annual capacity is based on the average number of slots funded by DJS, CCIF, and DSS during FY15 (n=301). 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, FY15

Region (DJS)	Jurisdiction(s) Served	Provider	Funding Source	# Funded Daily Slots
Baltimore	Baltimore City	VisionQuest	DJS	85
Central	Baltimore County	Baltimore County Bureau of Behavioral Health	CCIF DSS	27 18
	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 DJS Medicaid	8 72 4

Referrals to FFT

Although there was a reduction in capacity from the previous fiscal year (310 slots in FY14 versus 301 in FY15), there was a slight increase in the number of referrals to FFT from FY14 (n=1050) to FY15 (n=1057; Figure 5).

Maryland youth may be referred to FFT from a variety of sources. In FY15, the majority of the 1,057 referrals were made by DJS (75%), followed by DSS (10%), the provider agency (5%), and schools (4%; Figure 6). Six percent (6%) of referrals came from other sources, such as self-referrals from families, hospitals, and mental health agencies. DJS has been the principal referral source for FFT in Maryland since FY10.

Figure 5. Number of Referrals to FFT, FY13-FY15

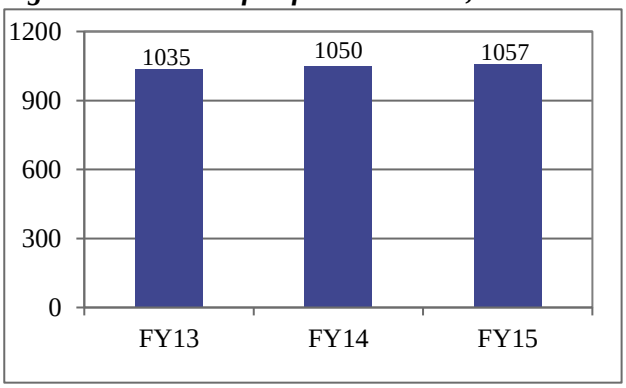
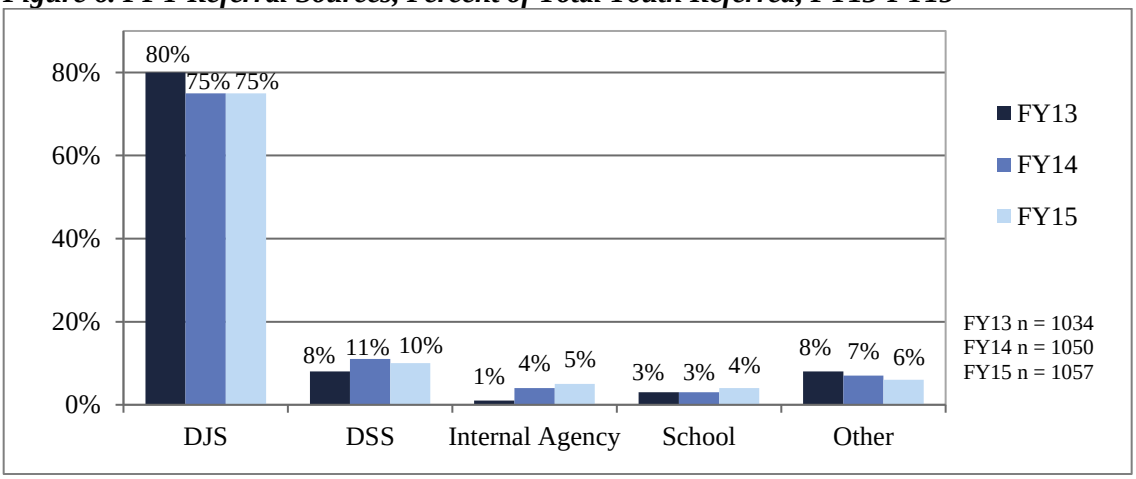


*Figure 6. FFT Referral Sources, Percent of Total Youth Referred, FY13-FY15**



*Referral source was missing for 1 case in FY13.

Characteristics of Referred Youth

FFT can serve male and female youth from diverse racial and ethnic backgrounds between the ages of 10 to 18 years old. In FY15, almost all referred youth met the age criteria for FFT. They tended to be older adolescents—61% were between the ages of 15 and 17 years old (Figure 7)—and the average age was 15.6 years old. Sixty-four percent (64%) of referred youth were African American/Black, 26% Caucasian/White, 5% Hispanic/Latino, and 5% another race/ethnicity (Figure 8). Further, 70% of these youths were male. Characteristics of youth referred to FFT have been consistent over the past few years.

Figure 7. Ages, Percent of Youth Referred to FFT, FY15

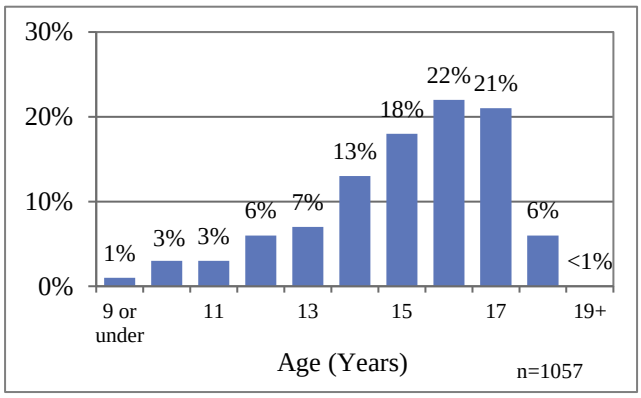


Figure 8. Demographic Characteristics of Youth Referred to FFT, FY13-FY15

	FY13*	FY14	FY15*
Total Number of Youth	1,035	1,050	1,057
Male	72%	70%	70%
Female	28%	30%	30%
African American/Black	65%	63%	64%
Caucasian/White	27%	27%	26%
Hispanic/Latino	5%	6%	5%
Other	3%	4%	5%
Average Age (s.d.)	15.9 (1.9)	15.7 (1.9)	15.6 (2.0)

*Race/ethnicity was missing for 1 case in FY13 and 1 case in FY15.

Referred Youth Who Did Not Start FFT

Not all youth referred to FFT start treatment (i.e., had a first visit, treatment consent is signed by the family). In some instances, the FFT provider may determine that the youth and/or family are not eligible for FFT or the youth/family may be eligible but they choose not to start for another reason. For the past three fiscal years, two-thirds or more of referred youth started FFT (Figure 9). Just under three-quarters of youth who did not start were eligible for FFT, including 232 youths in FY14 and 248 youths in FY15 (Figure 10).

Figure 9. Percent of Referred Youth Who Started FFT, FY13-FY15

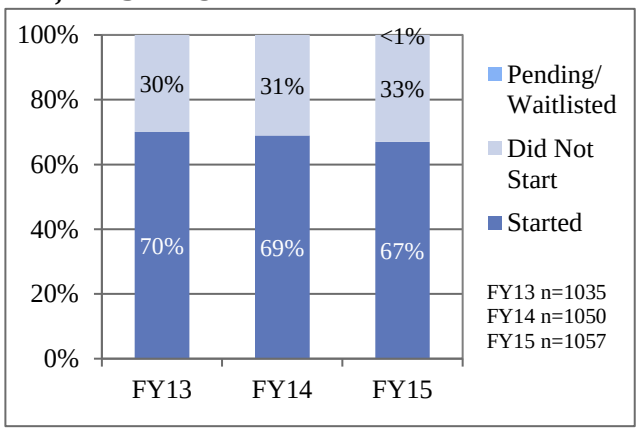
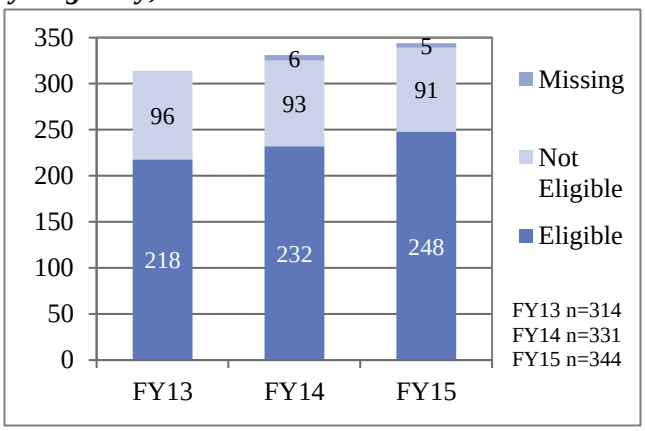


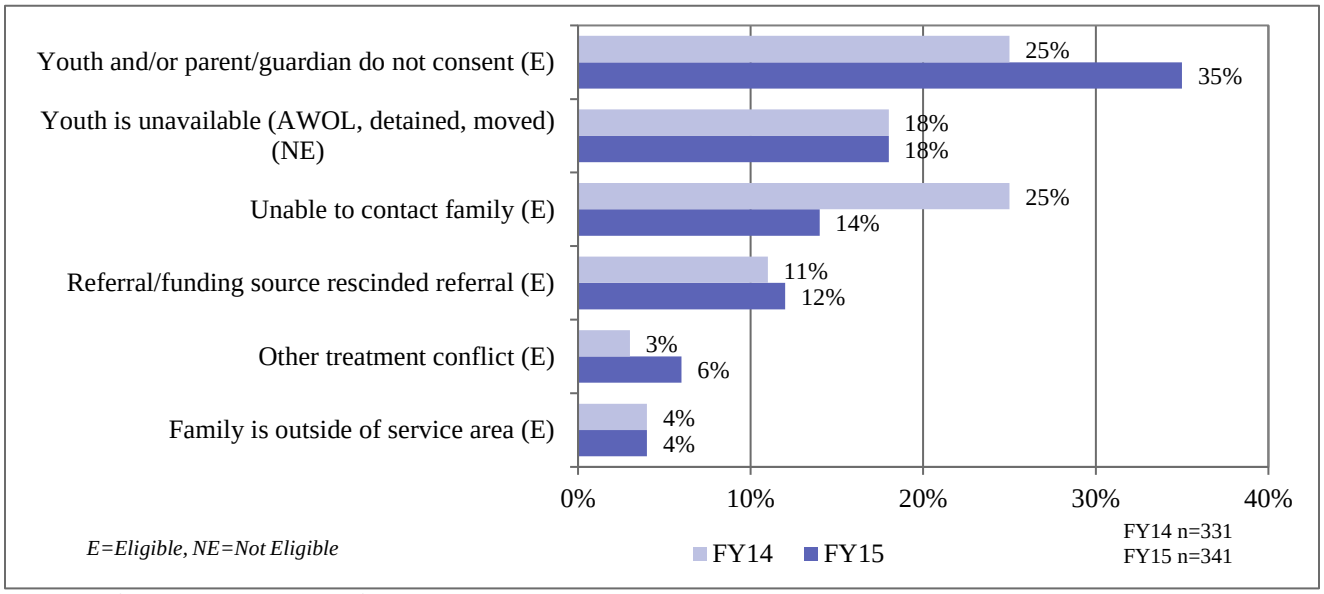
Figure 10. Number of Youth Who Did Not Start FFT by Eligibility, FY13-FY15



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 FY14 and FY15. In both years, close to half of youth did not start treatment due to reasons related to youth and family unwillingness or unavailability (51% in FY14 and 48% in FY15). In FY15, *youth and/or parent/guardian do not consent* accounted for over one-third (35%) of youth who did not start treatment.

Figure 11. Most Frequent Reasons for Not Starting FFT, Percent of Youth Who Did Not Start, FY14-FY15*



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

Waitlisted Youth

In FY15, 677 (64%) youths were placed on the waitlist—up from 383 (37%) in FY13 and 576 (55%) in FY14. Consistent with previous fiscal years, slightly less than one-third (30%) 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 if the youth/family are not quite ready to begin treatment at the time of referral (e.g., the youth is still in a facility). Seventy percent (70%) of youth were placed on the waitlist in FY15 because the *program was operating at capacity* (Figure 13). An additional 19% were waitlisted due to *staffing shortages*, and 5% (n=34) were placed on the waitlist *awaiting the youth's release from out-of-home placement*.

Figure 12. Percent of Waitlisted Youth Who Started FFT, FY13-FY15

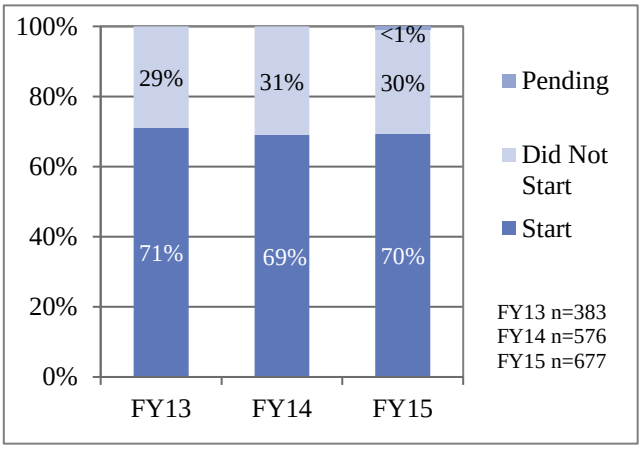
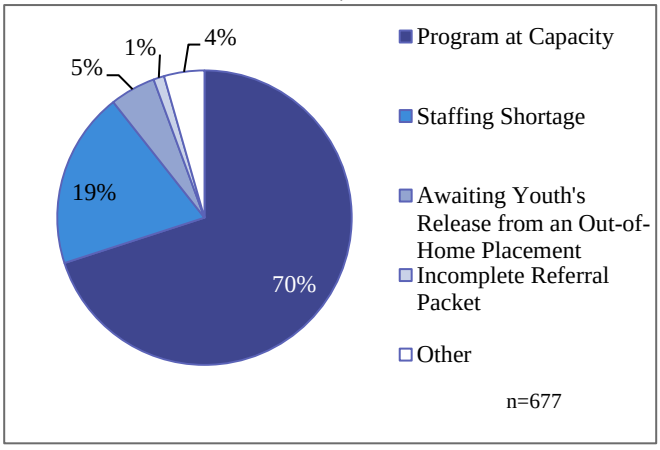


Figure 13. Waitlist Reasons, Percent of Youth Who Were Placed on the Waitlist, FY15

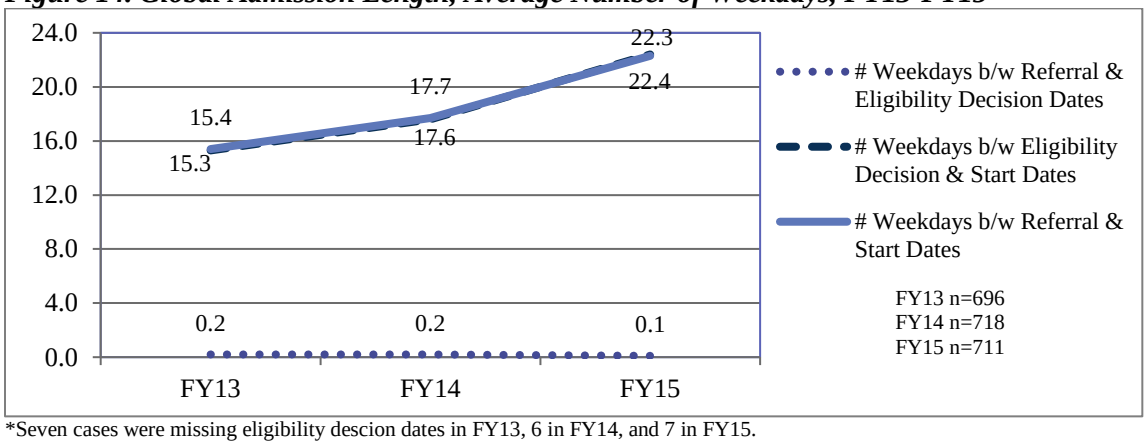


Youth Who Started FFT

Global Admission Length (Initial Case Processing)

Once a youth is referred to FFT, it is critical that an eligibility decision is made in a timely manner and that treatment starts soon thereafter. FFT providers report referral, eligibility decision, and start dates, so this process can be closely monitored. The number of days between the referral and start dates is referred to as the *global admission length*. The average global admission length has increased over the past three years (Figure 14). In FY15, providers generally made an eligibility decision within one weekday of receiving the referral, and youth typically started treatment within approximately four to five weeks (22 weekdays) of this decision.

Figure 14. Global Admission Length, Average Number of Weekdays, FY13-FY15*



*Seven cases were missing eligibility descion dates in FY13, 6 in FY14, and 7 in FY15.

Among the 711 youths who started FFT in FY15, 465 (65%) were temporarily placed on the waitlist. As shown in Figure 15, waitlisted youth took an average of 30 weekdays to enter treatment, while non-waitlisted youth took an average of eight weekdays. The duration of the admission process increased for waitlisted youth, relative to FY14.

There were a few statistical differences identified in the global admission length by subgroups of youth, as well as differences across agencies and jurisdictions (see Appendix 1). Notably, youth whose participation in FFT was funded by CCIF had a significantly longer global admission length (41.1 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 youths.

Figure 15. Global Admission Length by Waitlist Status, Average Number of Weekdays, FY14-FY15

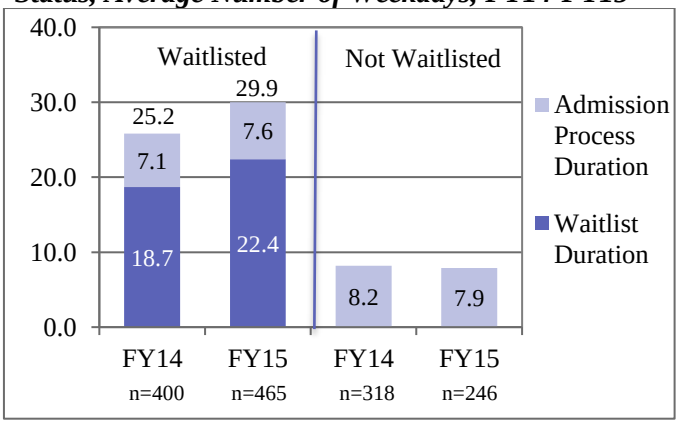
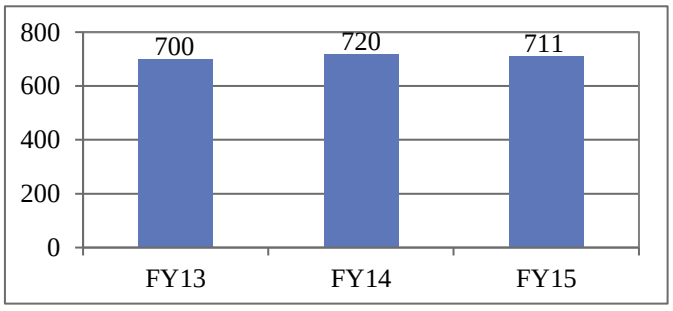


Figure 16. Number of Youth Who Started FFT, FY13-FY15

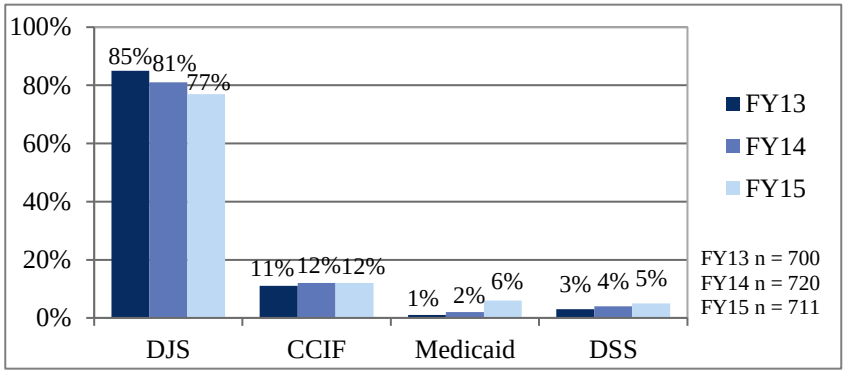


Utilization

A total of 711 youths started FFT in FY15 (Figure 16). The number of youth who started FFT has been consistent since FY13. DJS has been the primary funding source for FFT for the past few years;

accordingly, the majority of youth who started FFT in FY15 were funded by DJS (77%), followed by CCIF (12%), Medicaid (6%), and DSS (5%; Figure 17).

Figure 17. FFT Funding Sources, Percent of Youth Who Started, FY13-FY15



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 youth and their 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 a therapist is out on extended 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 FY15, DJS, CCIF, and DSS collectively funded a daily capacity of 301 FFT slots across Maryland (Figure 18). On average, 252 of these slots were "active", or available to youth and families for treatment. The average daily census of youth served by FFT was 201; thus, on average, 67% of funded slots, or 80% of active slots, were utilized. Both percentages are similar to their respective FY13 and FY14 levels.

Figure 18. FFT Utilization, FY13-FY15

	FY13	FY14	FY15
Avg. Number of Funded Slots	310	310	301
Avg. Number of Active Slots	272.0	268.3	251.5
Avg. Daily Census	218.8	216.4	201.4
Avg. Utilization of Funded Slots	71%	70%	67%
Avg. Utilization of Active Slots	80%	81%	80%

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 FY15 were between the ages of 15 and 17 years old (65%; Figure 19), and their average age was 15.8 years old. The majority of youth were male (70%) and African American/Black (66%; 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, FY15

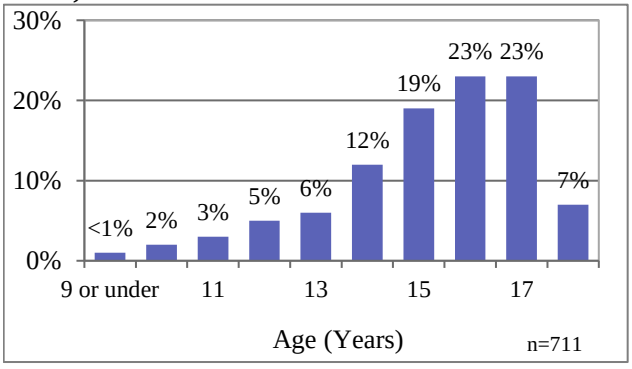
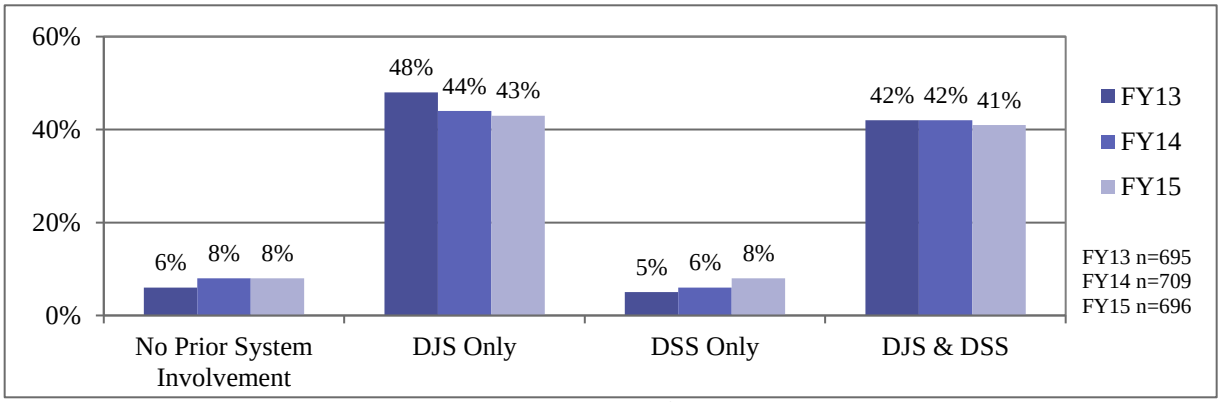


Figure 20. Demographic Characteristics of Youth Who Started FFT, FY13-FY15

	FY13	FY14	FY15
Total Number of Youth	700	720	711
Male	72%	72%	69%
Female	28%	28%	31%
African American/Black	64%	60%	66%
Caucasian/White	27%	28%	24%
Hispanic/Latino	6%	8%	5%
Other	3%	5%	5%
Average Age (s.d.)	16.0 (1.7)	15.9 (1.8)	15.8 (1.9)

The majority (92%) of youth who started FFT in FY15 were currently or previously involved with DJS and/or DSS. Slightly more than two-fifths (41%) had some form of involvement with both systems (Figure 21), similar to the cohorts of youth who started in FY13 and FY14 (42%).

Figure 21. Prior System Involvement, Percent of Youth Who Started FFT, FY13-FY15*



*Some youth could not be matched to DJS or DHR data due to missing identifiers (5 cases in FY13, 11 in FY14, and 14 in FY15); it is possible these 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. Of youth who started FFT between FY13 and FY15, only a small number of cases in FY13 (n=1) and FY15 (n=3) were missing information necessary for matching across systems. In FY15, 82% of matched youth had at least one prior complaint filed with DJS (Figure 22)—a slight decrease from FY14, when 85% of youth had at least one prior complaint. Of those with previous DJS involvement, youth had, on average, five prior DJS complaints, and their average age at first complaint was 13.7 years old. About one-quarter (26%) of youth had at least one prior committed residential placement with DJS, and this subset of youth averaged 1.8 prior placements.

Figure 22. Prior DJS Involvement, Percent of Youth Who Started FFT, FY13-FY15*

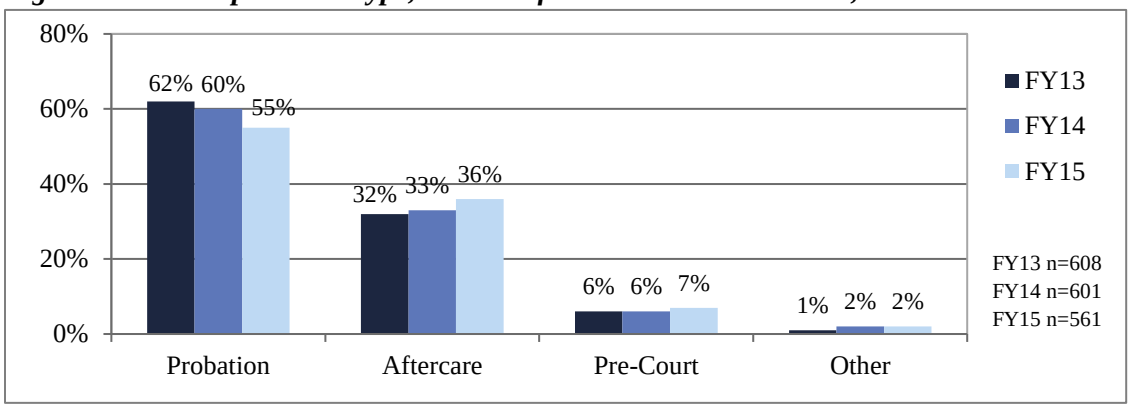
	FY13	FY14	FY15
Total Number of Youth	699	720	708
Any Prior DJS Complaints	89%	85%	82%
Avg. # of Prior DJS Complaints (s.d.)	4.5 (3.9)	4.7 (3.7)	4.9 (3.6)
Avg. Age at First DJS Complaint (s.d.)	13.9 (2.0)	14.0 (1.9)	13.7 (2.0)
Any Prior DJS Committed Residential Placements	24%	24%	26%
Avg. # of Prior DJS Committed Residential Placements (s.d)	1.6 (1.0)	1.8 (1.2)	1.8 (1.1)

*Some youth could not be matched to DJS data due to missing identifiers (1 case in FY13 and 3 in FY15); it is possible these additional youths were involved with DJS.

Seventy-nine percent (79%) of youth were actively involved with DJS when they started FFT—a slight decrease from prior fiscal years (87% in FY13; 83% in FY14). 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, 55% of DJS-involved youth were under probation, 36% aftercare (i.e., committed to DJS), 7% pre-court, and 2% other supervision.[4] Of youth under probation or aftercare supervision, 25% 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, 78 youths (15% of youth under aftercare or probation supervision) had been released from a committed residential placement within 30 days of starting FFT.

[4] 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, FY13-FY15*

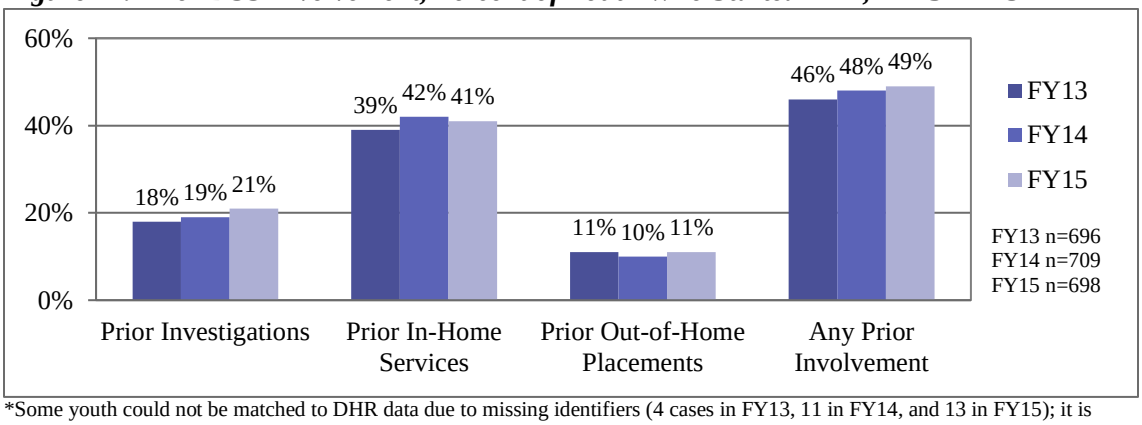


*Some youth could not be matched to DJS data due to missing identifiers (2 cases in FY13, 5 in FY15, and 6 in FY15); it is possible these additional youths were involved with DJS.

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, if any; again, only a small share could not be matched. Of youths who started FFT in FY15, 49% had some form of prior contact with the child welfare system (Figure 24). Prior to being referred to FFT, 21% of youth were part of a prior DSS investigation,[5] 41% had received in-home services, and 11% had been placed out of home. On average, youth were 7.8 years old at the time of their first in-home service and 7.3 years old at the time of their first out-of-home placement.[6]

Figure 24. Prior DSS Involvement, Percent of Youth Who Started FFT, FY13-FY15*



*Some youth could not be matched to DHR data due to missing identifiers (4 cases in FY13, 11 in FY14, and 13 in FY15); it is possible these additional youths 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, youth with DJS or Medicaid funding for treatment were more likely to start FFT in FY15. Rates of starting FFT also varied substantially by provider agency and jurisdiction; these figures can be found in Appendix 1.

Figure 25. Factors Related to Starting FFT in FY15

Characteristics of youth who were more likely to start FFT:

- ✓ Older at referral
- ✓ DJS or Medicaid funding for FFT
- ✓ Waitlisted

Not statistically related to starting FFT:

- x Gender
- x Race/Ethnicity
- x Prior DJS complaints
- x Prior DJS committed residential placements
- x Prior DSS involvement

[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 undercounted.

[6] Average age at first in-home service is based on 279 cases; 4 cases were excluded due to negative age values.

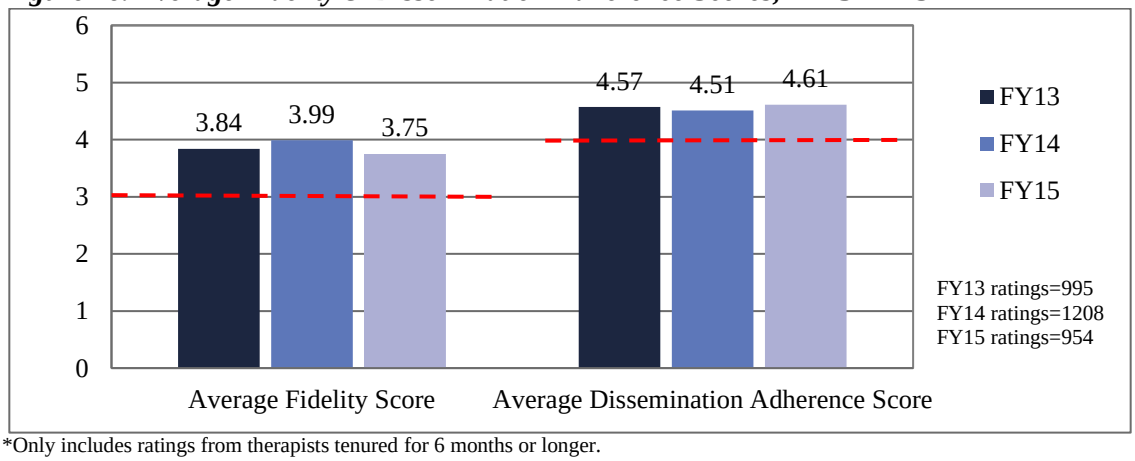
FFT Model Fidelity

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

Figure 26 illustrates the *Average Fidelity* and *Average Dissemination Adherence Scores* for all FFT teams in Maryland between FY13 and FY15. While the average fidelity score slightly decreased from an average of 3.99 in FY14 to 3.75 in FY15, the average dissemination score increased from 4.51 to 4.61; however, the teams continue to surpass the target scores.

Figure 26. Average Fidelity & Dissemination Adherence Scores, FY13-FY15*



*Only includes ratings from therapists tenured for 6 months or longer.

FFT Discharges & Outcomes

Of the 734 youths who were discharged from FFT in FY15, 662 (90%) were discharged for reasons *within therapist control*.[7] The remaining 10% of cases were discharged for reasons *outside of therapist control* (note that these cases are not included in subsequent analyses).[8]

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

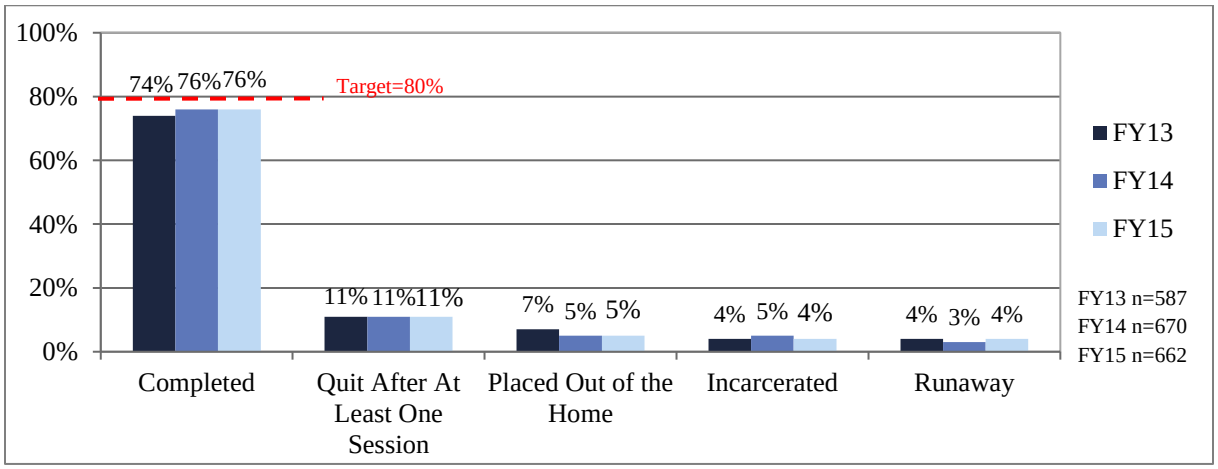
1) Did the youth and his/her family complete treatment (i.e., case progress)?
2) Were there sufficient changes in factors associated with problem behaviors (i.e., Outcome Questionnaire, Client Outcome Measure)?[9]
3) How was the youth doing in three primary areas of functioning at discharge (i.e., ultimate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

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

Case Progress at Discharge

Most youth *completed* FFT in FY15 (76%; Figure 27). Though this outcome has remained stable for the past three fiscal years (74% in FY13 and 76% in FY14), it still falls slightly below the national purveyor's 80% target. Of the remaining cases discharged within therapist control, 11% *quit after at least one session*, 5% of youth were *placed out of the home*,[11] 4% were *incarcerated*, and 4% *ran away*.

Figure 27. Discharge Reasons, Percent of Youth Discharged within Therapist Control from FFT, FY13-FY15



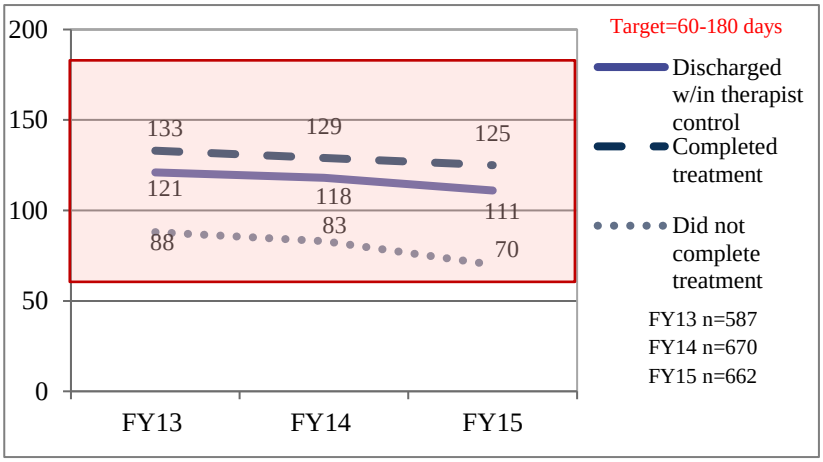
Bivariate analyses indicate that males were significantly less likely to complete FFT (73%) than were female youth (83%) in FY15. DJS- and Medicaid-funded youth (74% and 69%, respectively) were also significantly less likely to complete treatment than youth funded by DSS (86%) and CCIF (86%). Youth with no prior child welfare involvement and no prior DJS involvement were significantly more likely to complete treatment. 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 the home, incarcerated, and youth deceased.
[8] Discharge reasons for youth classified as *outside of therapist control* include: moved prior to completing the program, administrative discharge, and youth referred to other services. Of the 72 youths who were discharged outside of therapist control in FY15, 37 discharged due to administrative reasons, 27 moved, and 8 were referred to other services.
[9] FFT therapists routinely monitor each youth's behaviors and moods through assessments such as the Outcome Questionnaire (OQ) and Client Outcome Measure (COM).
[10] The Institute is working with FFT LLC to include data on changes in factors associated with problem behaviors in future reports.
[11] Out-of-home placements include, but are not limited to, substance abuse inpatient programs, group homes, or therapeutic group homes.

Length of Stay

The average length of stay (ALOS) in FFT treatment was 111 days, meeting the national purveyor's target of 60 to 180 days (Figure 28). The ALOS was substantially longer for youth who completed treatment (125 days) as compared with those who did not complete (70 days).

Figure 28. Length of Stay in FFT, Average Number of Days, FY13-FY15



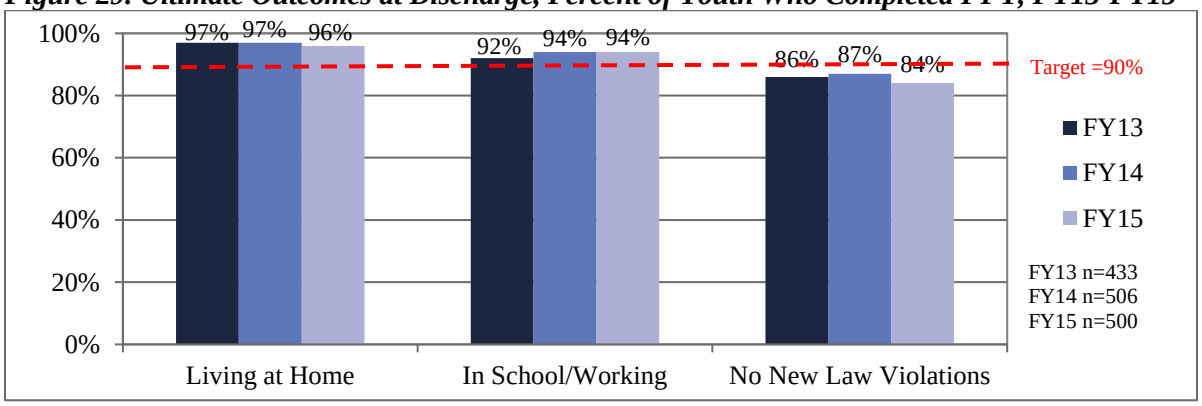
Length of stay in FFT was related to several youth characteristics in FY15 (Figure 29). Of those discharged within therapist control, youth with the following characteristics had significantly longer lengths of stay: females, younger at admission, no prior DJS complaints, no prior DJS committed residential placements, and placed on the waitlist. Length of stay varied substantially by funding source, with those funded by either DJS or Medicaid having significantly shorter lengths of stay than those funded by CCIF or DSS. Differences in lengths of stay by agency and jurisdiction are provided in Appendix 1. Race/ethnicity and having prior DSS involvement were not statistically related to length of stay.

Ultimate Outcomes at Discharge

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

Figure 29 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. In FY15, 84% of completers had *no new law violations* during treatment. Further, more than three-quarters (78%) of completers in FY15 had positive results for all three outcomes.

Figure 29. Ultimate Outcomes at Discharge, Percent of Youth Who Completed FFT, FY13-FY15



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). That stated, data provided by DJS and DPSCS is consistent with the ultimate outcomes, indicating that 17% of completers had been referred to DJS/arrested for a felony or misdemeanor offense while receiving FFT in FY15. In addition, DJS data show that 7% 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 FY12, FY13, and FY14, 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 (11 youths in FY12, 5 in FY13, and 8 in FY14).[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.

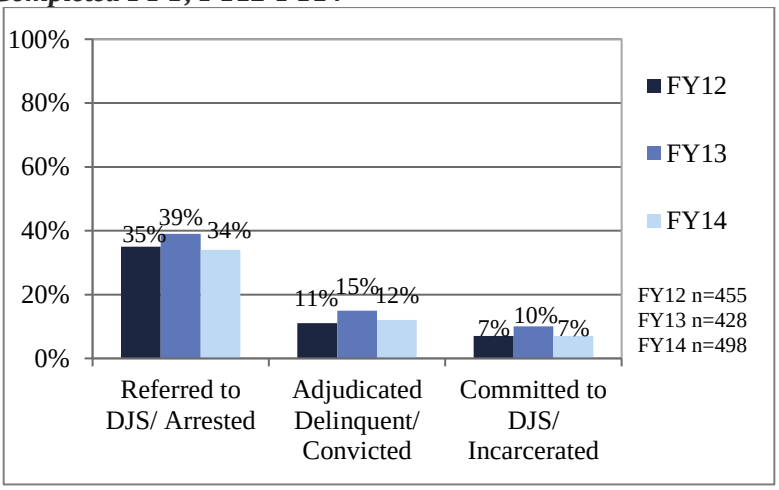
Adjudicated Delinquent/Convicted refers to any felony/ misdemeanor complaint that is adjudicated delinquent at a judiciary hearing or any adult arrest that results in a guilty finding at a criminal court hearing.

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.

Of youth who completed FFT in FY14, 34% were subsequently referred to DJS or arrested within one year of discharge (compared with 35% for FY12 and 39% for FY13; Figure 30). Smaller shares of youth were ultimately adjudicated delinquent/convicted (12% in FY14) and committed to DJS/incarcerated for these arrests (7% in FY14). Notably, there was a decrease in all justice system contact percentages for youth who completed FFT in FY14 compared to those for the FY13 cohort.

Figure 30. Juvenile & Criminal Justice System Involvement within 12 Months Post Discharge, Percent of Youth Who Completed FFT, FY12-FY14*



*One youth in FY12 could not be matched to DJS data due to missing identifiers.

According to bivariate analyses using all FFT completers from FY12 through FY14, African American/Black youth,

[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.

males, those with one or more prior DJS complaints, and those with one or more prior DJS committed residential placements were significantly more likely to be referred to DJS/arrested within one year following their FFT discharge. Substantial differences were also evident by agency and jurisdiction (Appendix 1). Having prior DSS involvement was not statistically related to having a DJS referral/arrest within one year of discharge.

Figure 31 summarizes subsequent involvement with DJS and/or DPSCS within 12 and 24 months for youth who completed FFT in FY12, FY13, and FY14. These numbers suggest that justice system involvement was driven primarily by contacts with the juvenile justice system, though 20% of FY12 completers and 24% of FY13 completers were arrested in the adult system within two years of discharge. Overall, 25% of the youth who completed FFT in FY13 had been adjudicated delinquent/convicted within 24 months of discharge, and 18% were subsequently committed to DJS/incarcerated.

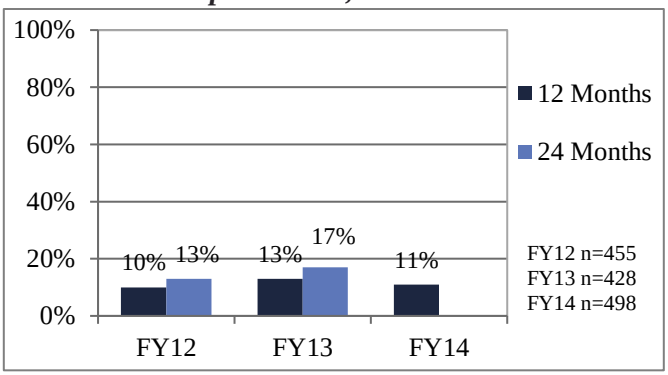
Figure 31. Juvenile & Criminal Justice System Involvement within 12 and 24 Months Post Discharge, Percent of Youth Who Completed FFT, FY12-FY14*

		FY12 (n=455)			FY13 (n=428)			FY14 (n=498)		
		Ref./ Arrest	Adj./ Convict.	Comm./ Incar.	Ref./ Arrest	Adj./ Convict.	Comm./ Incar.	Ref./ Arrest	Adj./ Convict.	Comm./ Incar.
DJS	12 Months	28%	9%	5%	27%	10%	5%	26%	9%	4%
	24 Months	34%	13%	6%	33%	14%	6%	--	--	--
DPSCS	12 Months	10%	2%	2%	14%	5%	5%	10%	3%	3%
	24 Months	20%	8%	7%	24%	13%	12%	--	--	--
DJS/ DPSCS	12 Months	35%	11%	7%	39%	15%	10%	34%	12%	7%
	24 Months	47%	20%	13%	51%	25%	18%	--	--	--

*One youth in FY12 could not be matched to DJS data due to missing identifiers.

DJS Committed Residential Placements. Youth who are committed to DJS do not need to commit a new offense and be processed through the juvenile court 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). Eleven percent (11%) of youth who completed FFT in FY14, as well as 10% in FY12 and 13% in FY13, were admitted to a residential placement by DJS during the 12 months following discharge (Figure 32). When the follow-up period is extended to two years, the majority of youth still avoided residential placement post-discharge; 13% of the youth who completed in FY12 and 17% of the youth who completed in FY13 were admitted to a committed residential placement by DJS within 24 months of discharge from FFT.[14]

Figure 32. DJS Committed Residential Placement within 12 and 24 Months Post Discharge, Percent of Youth Who Completed FFT, FY12-FY14*



*One youth in FY12 could not be matched to DJS data due to missing identifiers.

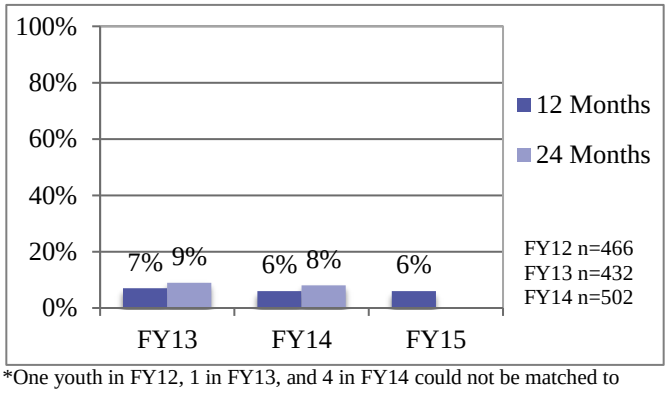
[13] Residential placements include places such as Youth Centers, group homes, residential treatment facilities, etc. It does not include detention.

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

Subsequent Involvement with the Child Welfare System

The Institute also provided DHR with the name, date of birth, and other demographic variables of all youths who were discharged prior to the last day of FY14 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 502 youths who completed FFT in FY14 and matched to DHR data, 6% had some form of DSS contact within 12 months of discharge (Figure 33)—1% had a new DSS investigation, 4% received in home services, and 1% were placed out-of-home (Figure 34). Of FFT completers in FY12 and FY13, 9% and 8%, respectively, had some form of new DSS contact within 24 months of discharge.

Figure 33. New Child Welfare Involvement within 12 and 24 Months Post Discharge, Percent of Youth Who Completed FFT, FY12-FY14*



*One youth in FY12, 1 in FY13, and 4 in FY14 could not be matched to DHR data due to missing identifiers.

Figure 34. Child Welfare System Involvement within 12 and 24 Months Post-Discharge, Percent of Youth Who Completed FFT, FY12-FY14*

	FY12 (n=466)			FY13 (n=432)			FY14 (n=502)		
	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	3%	4%	1%	1%	4%	2%	1%	4%	1%
24 Months	4%	5%	2%	1%	6%	2%	--	--	--

*One youth in FY12, 1 in FY13, and 4 in FY14 could not be matched to DHR data due to missing identifiers.

Cost of FFT in Maryland

In FY15, the total service delivery cost for providing FFT in Maryland was $3,342,684. 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 $4,554 per discharged youth (Figure 35).

Figure 35. Service Delivery Cost of FFT in Maryland, FY15

Number of Discharged Youths	734
Avg. Service Delivery Cost per Youth	$4,554
Total Service Delivery Cost	$3,342,684

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, DSS, 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 36. 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 FY15, the average per diem rates were $174 for treatment foster care programs, $214 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 $45. 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 8% of the cost per stay in therapeutic group homes and 7% 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.

Figure 36. Cost Analysis of FFT and Placements for DJS-Funded Youth, FY15*

Program Type	Average Per Diem Rate	Average Length of Stay (Days)	Avg. Cost per Stay/ Treatment
FFT	$45	98	$4,443
Treatment Foster Care	$174	386	$63,057
Group Home	$214	227	$48,569
Therapeutic Group Home	$259	227	$58,610

*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.

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