FUNCTIONAL FAMILY THERAPY IN MARYLAND: FY 2012 IMPLEMENTATION REPORT

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EXECUTIVE SUMMARY

Functional Family Therapy (FFT) is one of five prioritized evidence-based practices selected by Maryland's Children's Cabinet with the goals of reducing costly out-of-home placements and providing empirically supported community-based practices that address key outcomes (e.g., long-term rates of re-arrest, school attendance, etc.). Since 2007, the Institute for Innovation & Implementation has helped to facilitate FFT implementation in Maryland and continues to provide technical assistance and data reporting to providers and stakeholders.

FY12 Data Highlights

Utilization

- In FY12, FFT was available in 20 jurisdictions throughout Maryland. Based on the number of funded slots Maryland has the capacity to serve an estimated 969 youth annually.
- 1,049 youth were referred to FFT in FY12. The majority of referrals were provided by the Department of Juvenile Services (DJS) (76%). Of those youth referred, 69% were admitted for treatment, which was an increase from FY11. Issues regarding youth/family consent and availability were the primary reasons youth did not start FFT.
- The average age of youth admitted to FFT was 16.1 years old, and the majority of admitted youth were African American (63%) and male (74%). Most youth were involved with DJS upon admission to FFT, and these youth had considerable delinquency histories—on average, youth had more than 4 prior referrals to DJS. In addition, approximately one-third of youth admitted to FFT had prior involvement with the child welfare system.
- The statewide utilization of funded FFT slots was 71%, and utilization for 'active' slots was 79%.

Fidelity

- Fidelity to the FFT model has continued to exceed national FFT target scores and has shown improvement since FY11.

Outcomes

- 646 youth were discharged from FFT within the therapist's control in FY12, and **74%** of these youth had completed treatment, which is an improvement over previous years.
- Of youth who completed FFT in FY12, at the time of discharge:
  - **97%** were living at home;
  - **96%** were in school or working; and
  - **96%** had no new arrests.
- Of youth who completed FFT in FY11, as of one year post-discharge:
  - **65%** did not have a new DJS referral;
  - **94%** had not been committed to DJS; and
  - **89%** had not been placed into a residential placement with DJS.
  - Only **3%** of youth had any new involvement with the child welfare system.

Introduction

Purpose of this Report

In 2007, Maryland's Governor's Office of Children (GOC), on behalf of the Children's Cabinet, Department of Juvenile Services (DJS), and local Departments of Social Services began to work collaboratively to substantially increase the availability of Functional Family Therapy (FFT) to youth and families in Maryland. FFT is a family-based clinical model that can be delivered in the home and is designed to help youth with behavior problems. It is widely recognized as an evidence-based practice (EBP), suitable for diverse populations in diverse contexts and settings (Sexton & Alexander, 2000; Sexton, 2011). Maryland's stakeholders selected FFT with the goals of reducing the use of out-of-home placements while improving outcomes for youth and families across the State.

The Institute for Innovation & Implementation (The Institute) collects and analyzes data for a variety of EBPs utilized throughout Maryland in order to monitor and support their implementation efforts. This report provides state and local stakeholders with a summary of FFT implementation across the State of Maryland as of fiscal year (FY) 2012. In addition to utilization and FFT 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 exhibit delinquent and violent behaviors, as well as school and other conduct problems. The therapeutic model consists of five major components 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. FFT has demonstrated positive outcomes across a wide range of youth and communities, including:

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

The FFT model 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; Sexton & Alexander, 2000; Sexton, 2011). For additional information on FFT, please go to www.fftinc.com.

Assessing FFT Utilization and Outcomes

The data presented in this report were drawn from multiple sources and fall into three main categories.

- ***Utilization data*** are drawn from youth-level data routinely submitted by providers in Maryland, as well as data provided by DJS and the Department of Human Resources (DHR). These data include demographic information, delinquency history, child welfare system history, and details of the 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. Readers should note that use of the data collection instrument did not begin until January 2010, and data from July through December 2009 were collected retrospectively. While FY10 data are presented in this report, these findings should be interpreted with caution, as they may reflect some missing information.
- ***Fidelity data*** measure the degree to which the EBP has been delivered as intended by the program developers.
- ***Outcomes data*** allow us to assess whether FFT has achieved the desired results for youth and families. 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). The different types of outcome data collected are detailed in Table 1.

Table 1. FFT Outcome Data—Types and Sources

Type	Indicator	Source
Case Progress	➢ Treatment completion ➢ Reason for non-completion (if applicable)	FFT Providers
Ultimate Outcomes at Discharge	➢ Whether the youth was living at home ➢ Whether the youth was in school or working ➢ Whether the youth had any new arrests	FFT Providers
Longitudinal Outcomes	➢ Delinquency (e.g., DJS referral, adjudication, and commitment) ➢ Involvement in the child welfare system (e.g., services and placements)	DJS DHR

Descriptive and bivariate analyses (e.g., chi-square, t-test) are utilized to assess statewide utilization, fidelity, and outcomes data from FY12. Where possible, data are presented and comparisons are drawn for previous fiscal years. Please refer to Appendix 1 for FY12 descriptive data presented by funding source, provider, and jurisdiction.

Where was FFT Offered in Maryland?

In FY12, FFT was offered in 20 jurisdictions[1] in Maryland; it was not available in the DJS Western Region of the State (Figure 1). FFT was administered by three providers (five FFT teams total)—Baltimore County Bureau of Behavioral Health (one team), Center for Children (two teams), and VisionQuest (two teams)—for an estimated annual capacity of 969 youth.[2] FFT was funded by four sources, including DJS, the Children's Cabinet Interagency Fund (CCIF), a local Department of Social Services (DSS), and Medicaid. Funding sources and slot allocations varied by jurisdiction (see Table 2).

Figure 1. FFT Availability in Maryland, FY12

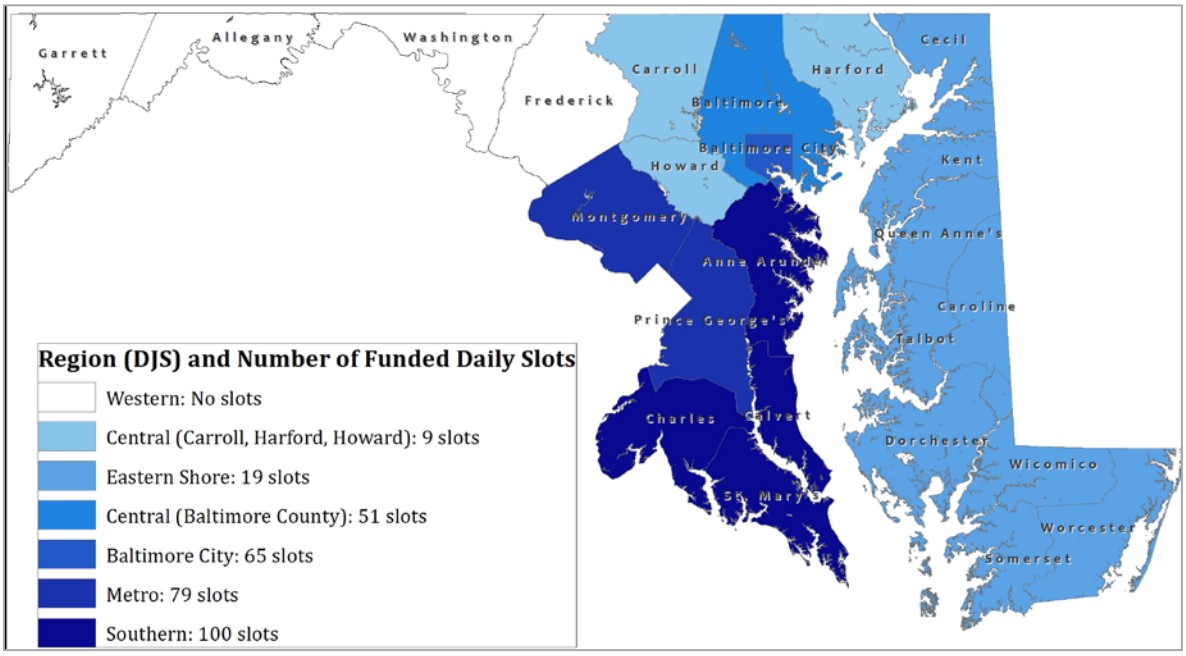


Table 2. FFT Service Provision & Funding Sources in Maryland, FY12

Region (DJS)	Jurisdiction(s) Served	Provider	Funding Source	# Funded Daily Slots
Baltimore	Baltimore City	VisionQuest	DJS	65.0
Central	Baltimore County	Baltimore County Bureau of Behavioral Health VisionQuest	CCIF DSS DJS	30.0* 18.0 3.0
	Carroll, Howard, Harford	VisionQuest	DJS	9.0
Eastern Shore	Cecil , Caroline, Dorchester, Kent, Queen Anne, Somerset, Talbot, Wicomico, Worcester	VisionQuest	DJS	19.0
Metro	Montgomery, Prince George's	VisionQuest	DJS	79.0
Southern	Anne Arundel, Calvert, Charles, St. Mary's	Center for Children	CCIF DJS Medicaid	6.7* 93.0 --

*The number of funded slots changed in this jurisdiction during FY12. The *# Funded Daily Slots* represents a weighted average of the number of slots based on these changes.

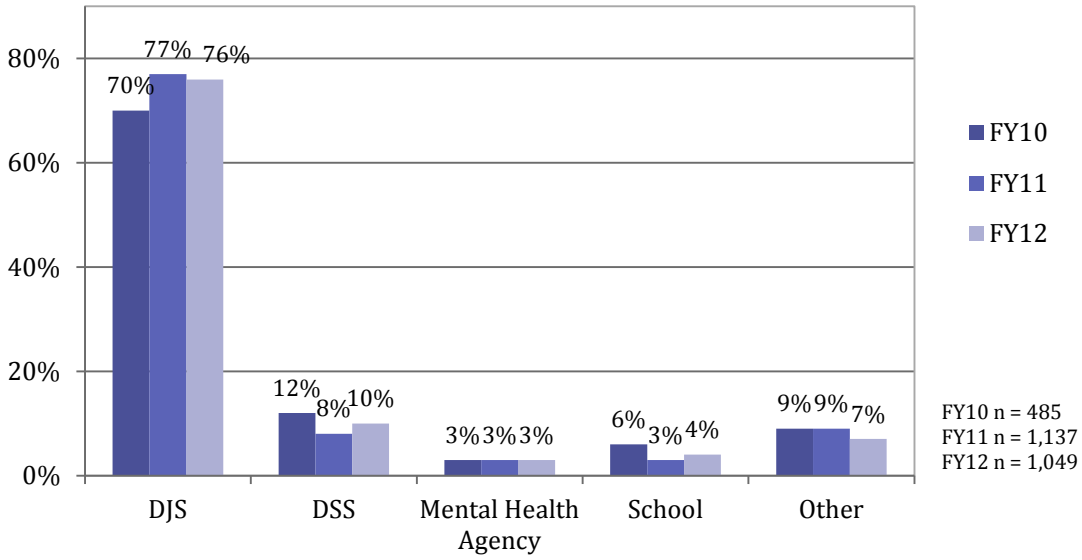
[1] Jurisdictions refer to all Maryland counties and Baltimore City.

[2] This estimated number is based on the average number of slots funded by DJS, CCIF, and DSS during FY12 (n=323). It assumes that each youth will remain in FFT for an average length of stay of 120 days, and that three youth can be served in each slot during the course of the year.

Referrals to FFT

Maryland youth may be referred to FFT from a variety of sources. In FY12, the majority of the 1,049 referrals were made by DJS (76%), followed by DSS (10%), schools (4%), and mental health/outpatient agencies (3%; Figure 2). Seven percent of referrals came from other sources, such as self-referrals from families, hospitals, and other local agencies. DJS has been the principal referral source for FFT in Maryland since FY10.

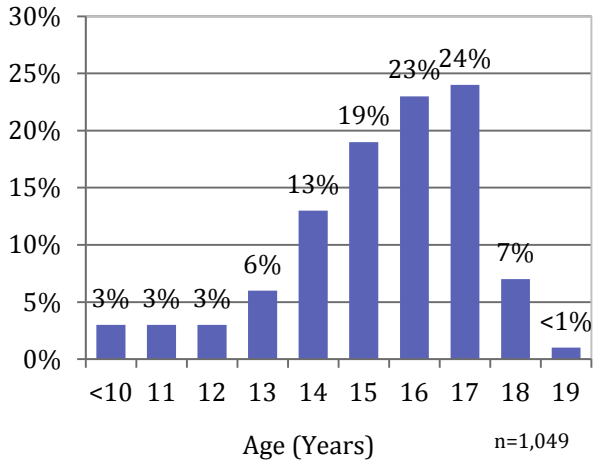
Figure 2. FFT Referral Sources, Percentage of Total Youth Referred , FY10-FY12



Characteristics of Referred Youth

FFT can serve male and female youth from diverse racial and ethnic backgrounds who are between the ages of 10 to 18 years old. In FY12, almost all of the referred youth met the age criteria, though they tended to be older adolescents. Approximately two-thirds (66%) of referred youth were between the ages of 15 and 17 years old (Figure 3), and the average age at referral was 15.8 years old. Sixty-two percent of referred youth were African American/Black, 28% Caucasian/White, 5% Hispanic/Latino, and 5% another race/ethnicity (Table 3). Further, 73% of these youth were male.

Figure 3. Ages of Youth Referred to FFT, FY12



Characteristics of youth referred to FFT have been fairly constant over time, with the exception of race. Since FY10, the proportion of African American/Black youth referred in Maryland has significantly increased, while the proportion of Caucasian/White youth has decreased.

Table 3. Demographic Characteristics of Youth Referred to FFT, FY10-FY12

		FY10	FY11	FY12
	Total Number of Youth	485	1,137	1,049
Gender	Male	355 (73%)	827 (73%)	764 (73%)
	Female	130 (27%)	310 (27%)	285 (27%)
Race/Eth.	African American/Black	274 (57%)	763 (67%)	648 (62%)
	Caucasian/White	170 (35%)	303 (27%)	296 (28%)
	Hispanic/Latino	18 (4%)	33 (3%)	54 (5%)
	Other	23 (5%)	33 (3%)	51 (5%)
	Average Age (s.d.)	15.6 (2.0)	15.8 (1.9)	15.8 (1.9)

Referred Youth Who Did Not Start FFT

Not all youth referred to FFT start treatment. In some cases, the FFT provider may determine that the youth and/or family are not eligible for FFT treatment, and in other cases, the youth/family may be eligible but they choose not to start for another reason. Figure 4 lists the reasons for not starting FFT, which are indicated by the providers. These reasons are closely monitored over time as they offer important information about how to improve the referral process, including how to increase appropriate referrals and decrease barriers to treatment engagement. Ultimately, utilization is highly dependent on a sufficient flow of referrals for eligible youth and families who could benefit from FFT.

Figure 4. Reasons for Not Starting FFT

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

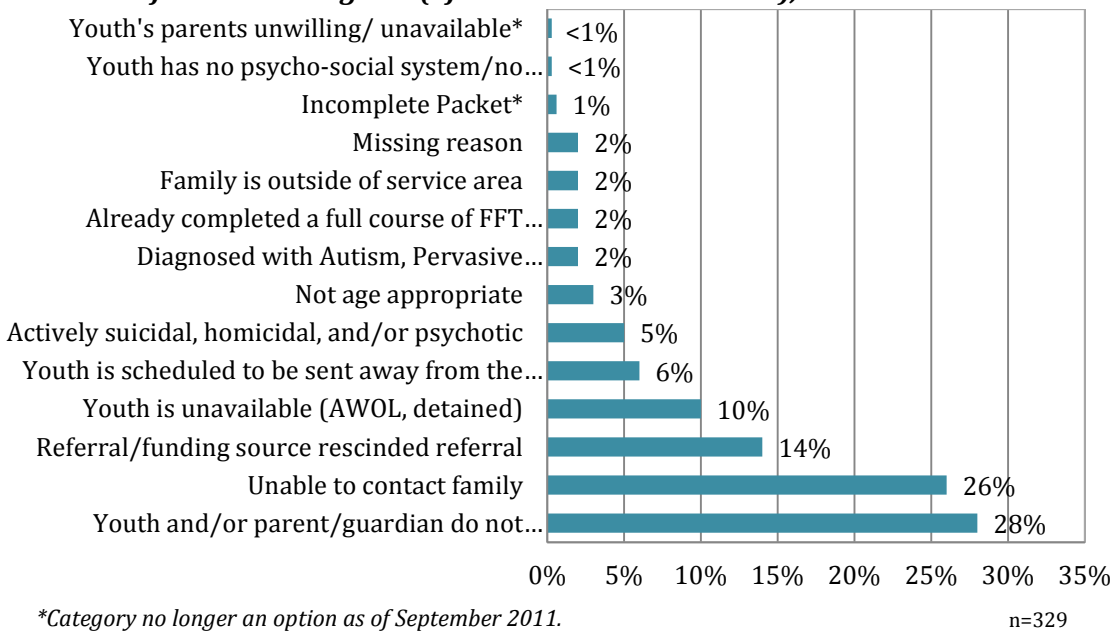
- *Age appropriateness;*
- *Actively suicidal, homicidal, and/or psychotic;*
- *Diagnosed with autism, pervasive developmental delay, mental retardation, or with an IQ less than 75;*
- *Diagnosed primarily as a sex offender;*
- *No psycho-social system/ identifiable caregiver;*
- *Scheduled to be sent away from the family;*
- *Already completed a full course of FFT treatment; or*
- *Unavailable (AWOL, detained).*

Youth may not start FFT despite being **eligible** because:

- *The referral/funding source rescinded the referral;*
- *The youth and/or parent/ guardian do not consent and there is no court order;*
- *The family cannot be contacted; or*
- *The family is outside of the service area.*

Figure 5 shows the reasons that youth did not start FFT in FY12 (n=329). The most frequent reason was *youth and/or parent/guardian do not consent and there is no court order* (28%), followed by *unable to contact family* (26%) and *referral/funding source rescinded referral* (14%). In all three circumstances, these youth were eligible for FFT. Only 28% of youth did not start FFT because they were deemed ineligible.

Figure 5. Reasons for Not Starting FFT (of Youth who Did Not Start), FY12



**Category no longer an option as of September 2011.*

n=329

Further examination of cases in which youth/families did not start FFT reveals several trends over time. For one, the percentage of referred youth who did not start FFT decreased from 38% in FY11 to 31% in FY12. Second, a smaller percentage of referrals were rejected in FY12 because the youth/family was not eligible (28%) relative to FY11 (38%). Further, it is evident that youth and family unwillingness or unavailability to participate has been a predominant issue since FY10; in FY12, this cluster of reasons constituted 56% of youth/families who did not start. (Note: The reasons for not starting FFT have been revised over time, so trends for specific reasons cannot be assessed.) Taken as a whole, these findings suggest that improved communication between FFT providers and referral agencies has contributed to in an increase of appropriate referrals, which, in turn, has impacted the percentage of youth and families not starting. On the other hand, a lack of youth and family engagement at the beginning of treatment has been a continual issue.

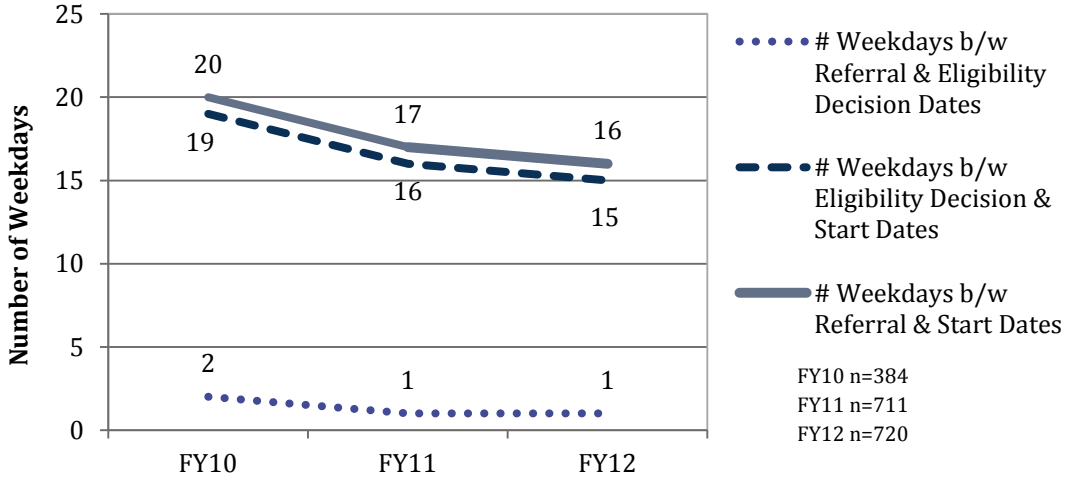
Admissions to FFT

Initial Case Processing (Global Admission Length)

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*.

Global admission length has been declining over the past three years (Figure 6). In FY12, providers generally made an eligibility decision within one weekday of receiving the referral, and youth typically started treatment within approximately three weeks (15 weekdays) of this decision. There were a number of statistical differences in the global admission length by subgroups of youth (see Table 4; only significant differences shown), as well as differences across agencies and jurisdictions (Appendix 1).

Figure 6. Global Admission Length, FY10-FY12



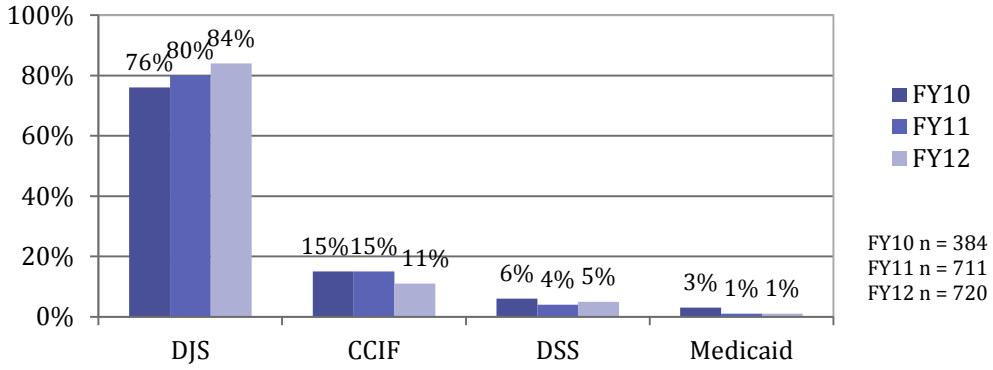
Note: *Due to a change in data collection procedures, eligibility decision dates were only available for 237 cases in FY10.*

Table 4. Statistically Significant Differences in Global Admission Length (GAL; days)		
Factor	**Shorter GAL**	**Longer GAL**
Gender	Male (13.4)	Female (22.2)
Age at Admission	15 years and older (13.9)	Under 15 years old (21.5)
Race/Ethnicity	African American/Black (13.3) Hispanics/Latinos (9.8)	Caucasian/White (22.9)
Prior Referrals to DJS	Yes (13.1)	No (31.4)
Prior DJS Commitments	Yes (10.2)	No (17.2)
Funding Source	DJS (12.3) DSS (17.5)	GOC/CCIF (36.9) Medicaid (77.8)

Utilization

DJS has been the primary funding source for FFT during the past few years; accordingly, the majority of youth admitted to FFT in FY12 were funded by DJS (84%), followed by CCIF (11%), and DSS (5%; Figure 7). Just 1% of youth were funded through Medicaid.

Figure 7. FFT Funding Sources, Percentage of Youth Admitted , FY10-FY12



Given the investment to make FFT available to youth and families, 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 also impacted by the availability of therapists (e.g., if the therapist is out on leave or away for training, or a position vacancy). 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 FY12, DJS, CCIF, and DSS collectively funded a daily capacity of 323 FFT slots across Maryland (Table 5). Of these slots, an average of 290 was 'active', or available to youth and families for treatment. The average daily population of youth served by FFT was 230. Therefore, the average statewide utilization of funded slots was 71%, and utilization for 'active' slots was 79%. The remainder of this section describes the types of youth who participated in FFT.

Table 5. FFT Utilization, FY12

Average Number of Funded Slots (Daily)	323
Average Number of Active Slots (Daily)	290
Average Daily FFT Population	230
Average Utilization of Funded Slots	71%
Average Utilization of Active Slots	79%

Characteristics of Admitted Youth

Overall, 720 youth were admitted to FFT in FY12, a slight increase from FY11 (n=711). The characteristics of youth admitted to FFT were similar to those of the referral population. Most youth admitted to FFT in FY12 were between the ages of 15 and 17 years old (70%; Figure 8), and their average age was 16.1 years old. The majority of youth were male (74%) and African American/Black (63%; Table 6). The characteristics of youth admitted to FFT have remained relatively stable over time, with the exception of race/ethnicity.

Figure 8. Ages of Youth Admitted to FFT, FY12

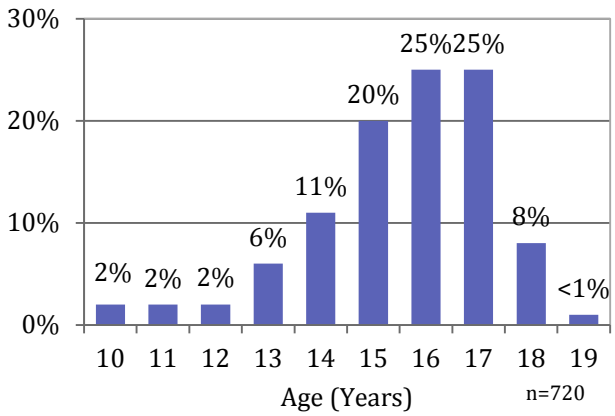


Table 6. Demographic Characteristics of Youth Admitted to FFT, FY10-FY12

		FY10	FY11	FY12
	Total Number of Youth	384	711	720
Gender	Male	286 (75%)	511 (72%)	536 (74%)
	Female	98 (25%)	200 (28%)	184 (26%)
Race/Eth.	African American/Black	217 (56%)	474 (67%)	452 (63%)
	Caucasian/White	133 (35%)	194 (27%)	181 (25%)
	Hispanic/Latino	14 (4%)	23 (3%)	52 (7%)
	Other	20 (5%)	20 (3%)	35 (5%)
	Average Age (s.d.)	15.8 (1.8)	16.0 (1.8)	16.1 (1.7)

Involvement with DJS

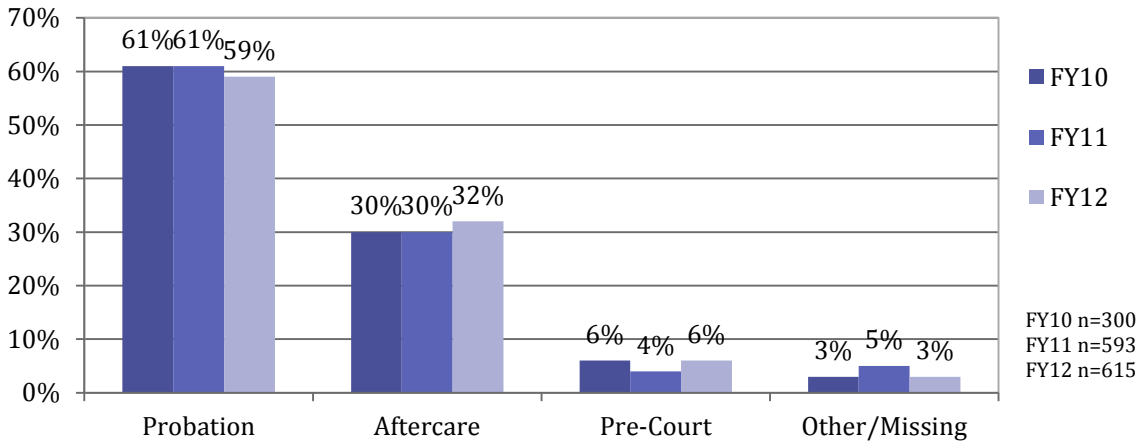
In FY12, 86% of youth admitted to FFT had at least one prior referral to DJS, representing a slight increase compared with youth admitted the previous two years (Table 7). Of those with previous DJS involvement, youth had, on average, more than four prior DJS referrals and their mean age at first referral was 13.9 years old. Twenty-two percent of admitted youth had at least one prior commitment to DJS, and this subset of youth averaged 1.6 prior commitments.

Table 7. Prior DJS Involvement for Youth Admitted to FFT, FY10-FY12

	FY10	FY11	FY12
Total Number of Youth	384	711	720
One or More Prior DJS Referrals	303 (79%)	601 (85%)	620 (86%)
Avg. # of Prior DJS Referrals (s.d.)	4.8 (3.3)	4.8 (3.7)	4.6 (3.7)
Avg. Age at First DJS Referral (s.d.)	13.6 (2.0)	13.8 (2.0)	13.9 (2.0)
One or More Prior DJS Commitments	73 (19%)	142 (20%)	161 (22%)
Avg. # of Prior DJS Commitments (s.d)	1.5 (1.0)	1.7 (1.1)	1.6 (1.1)

Eighty-five percent of the admitted youth had some form of active involvement with DJS (Figure 9). Of these, 59% were under probation supervision, 32% aftercare supervision (i.e., committed to DJS), 6% pre-court supervision, and 3% were under another form of supervision (e.g., administrative) or missing this information. Of youth under probation or aftercare supervision, 21% 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, 66 youth (12% of youth under aftercare or probation supervision) had been released from a committed residential placement within 30 days of starting FFT.

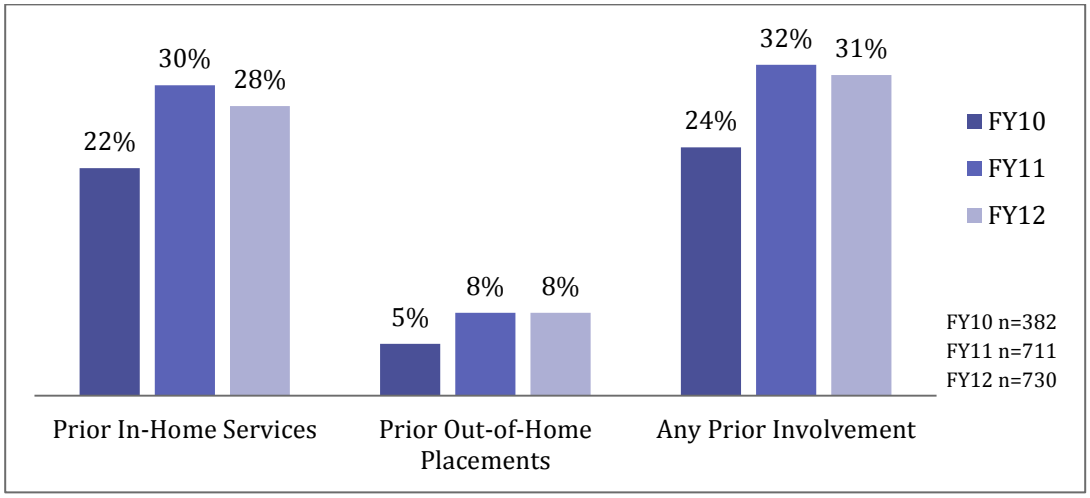
Figure 9. DJS Supervision for Youth Admitted to FFT, FY10-FY12



Involvement with DSS

Of the 720 youth admitted to FFT in FY12, 223 (31%) had some form of prior contact with the child welfare system (Figure 10). Prior to being referred to FFT, 54 youth (8%) had been placed out-of-home, and 204 (28%) had received in-home services. On average, youth were 5.6 years old at the time of their first out-of-home placement, and 7.7 years old at the time of their first in-home service.[3]

Figure 10. Prior Child Welfare System Involvement for Youth Admitted to FFT, FY10-FY12



Simple bivariate analyses were conducted to determine if youth who started FFT differed from those who did not start. These findings are summarized in Figure 11. Notably, youth belonging to a minority race/ethnicity and those with prior DJS and DSS involvement were more likely to start FFT in FY12. Also note that rates of admission varied substantially by provider agency and jurisdiction; these figures can be found in Appendix 1.

Figure 11. Factors Related to Starting FFT

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

- ✓ Belong to a minority race/ethnicity
- ✓ Be older at the time of referral to FFT
- ✓ Have one or more prior DJS referral
- ✓ Have prior DSS involvement
- ✓ Have DJS funding for FFT

Starting FFT was not statistically related to:

- x Gender
- x Having one or more prior DJS commitments

[3] Average age at first in-home service is based on 203 cases; one case was excluded due to a negative age value.

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.

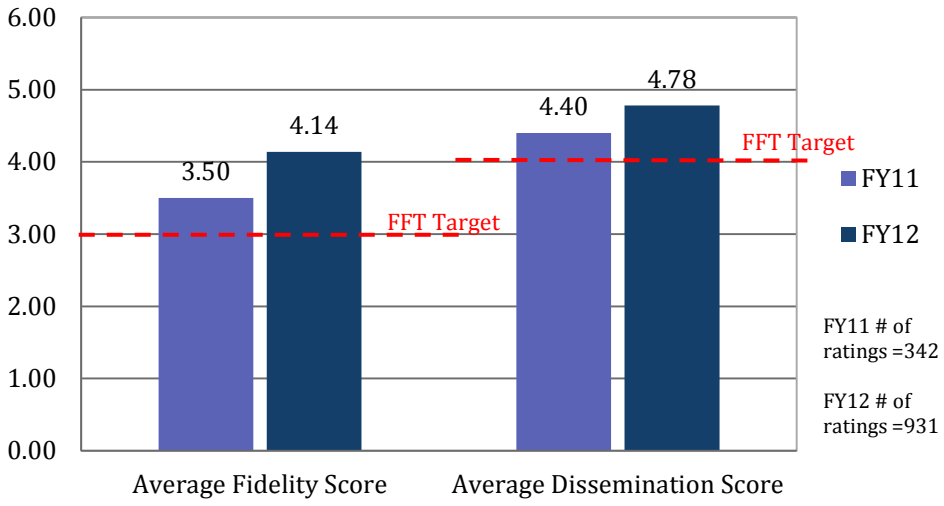
Two primary measures are utilized to assess FFT Fidelity—the *Average Fidelity Score* and the *Average Dissemination Adherence Score*.

- The ***Average 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 ***Average 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). The ratings are based on the degree to which the therapist is completing all of the 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 12 illustrates the *Average Fidelity* and *Average Dissemination Adherence Scores* for all FFT teams in Maryland during FY11 and FY12. Both measures indicate an improvement over the past two years.

Figure 12. FFT Provider Fidelity & Dissemination Adherence, FY11-FY12



FFT Discharges & Outcomes

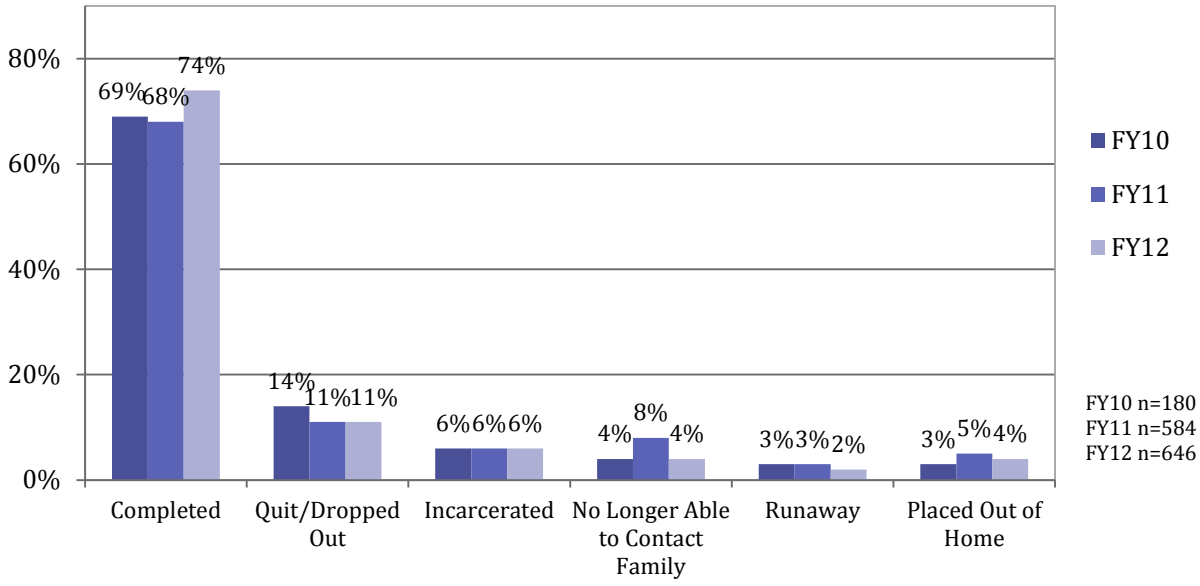
Of the 736 youth who discharged from FFT in FY12, 646 (88%) were discharged for reasons *within therapist control*. The remaining 12% of cases were discharged for reasons *outside of therapist control*; note that these cases will not be included in subsequent analyses. The specific discharge reasons falling under each category are listed in Figure 13.

Figure 13. Discharge Reasons

Within Therapist Control	Outside of Therapist Control
➢ Completed treatment ➢ Quit/dropped out after contact ➢ Youth was incarcerated for a new charge during treatment ➢ Therapist no longer able to contact youth/family ➢ Youth ran away ➢ Youth was placed out of home	➢ Youth/family moved ➢ Youth referred to other services ➢ Administrative reasons ➢ Youth incarcerated/placed for pre-referral reasons

As shown in Figure 14, the majority of youth completed FFT (74%, n=477), and this outcome has improved as compared with previous cohorts (69% in FY10 and 68% in FY11). Of those who did not complete treatment, the most common reasons were that the *youth/family quit or dropped out* (11%) and the *youth was incarcerated for a new charge during treatment* (6%). Four percent of youth were *placed out-of-home* (e.g., in a substance abuse inpatient program, group home, or therapeutic group home), and in another 4% of cases the *therapist was no longer able to contact the family*.

Figure 14. Discharge Reasons for Youth Discharged from FFT, FY10-FY12



Preliminary analyses reveal some significant differences between youth who completed FFT and those who did not (of youth discharged within the therapist's control; Figure 15). Notably, African American/Black youth were less likely to complete FFT (68%) compared with Caucasian/White youth (84%) and youth of other races/ethnicities (81%). Further, youth with prior referrals to DJS were less

likely to complete FFT (72% versus 84% for those with none), as were those who had been previously committed to DJS (65% versus 76% for those who had not) and those with prior involvement with the child welfare system (65% versus 78% for those without involvement). There were also substantial variations by funding source, provider agency, and jurisdiction (see Appendix 1).

Length of Stay

The average length of stay (ALOS) in FFT treatment was 126 days—close to the national purveyor's target of 90-120 days (Figure 16). It was significantly longer for youth who completed the program (136 days), as compared with those who did not complete (97 days). The ALOS has generally decreased over time, aligning more closely with the expectation of the model.

Figure 15. Factors Related to Completing FFT

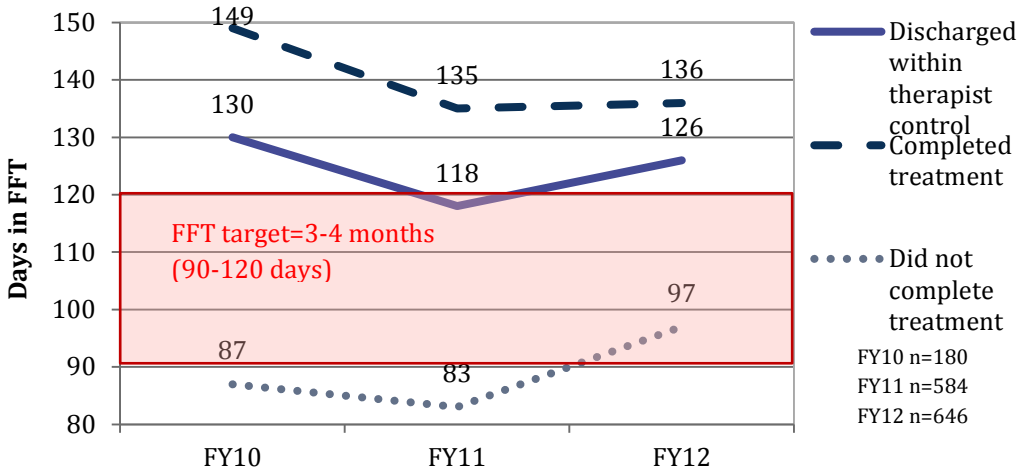
Youth who completed FFT were statistically <u>more likely</u> to:

- ✓ Be Caucasian/White or of another race/ethnicity (non-African American)
- ✓ Have no prior DJS involvement
- ✓ Have no prior DSS involvement
- ✓ Have a longer length of stay

Completing FFT was not statistically related to:

- x Gender
- x Age at admission
- x Global admission length

Figure 16. Length of Stay in FFT, FY10-FY12



The length of stay in FFT treatment was related to several youth characteristics (Table 8). Of those discharged within therapist control, the following types of youth had significantly longer lengths of stay: those who were younger (under 15 years old), had no prior DJS referrals, and had no prior DJS commitments. Again, length of stay varied substantially by funding source, agency, and jurisdiction. Gender, race/ethnicity, and prior DSS involvement were not statistically related to length of stay.

Table 8. Statistically Significant Differences in Lengths of Stay (LOS; days)

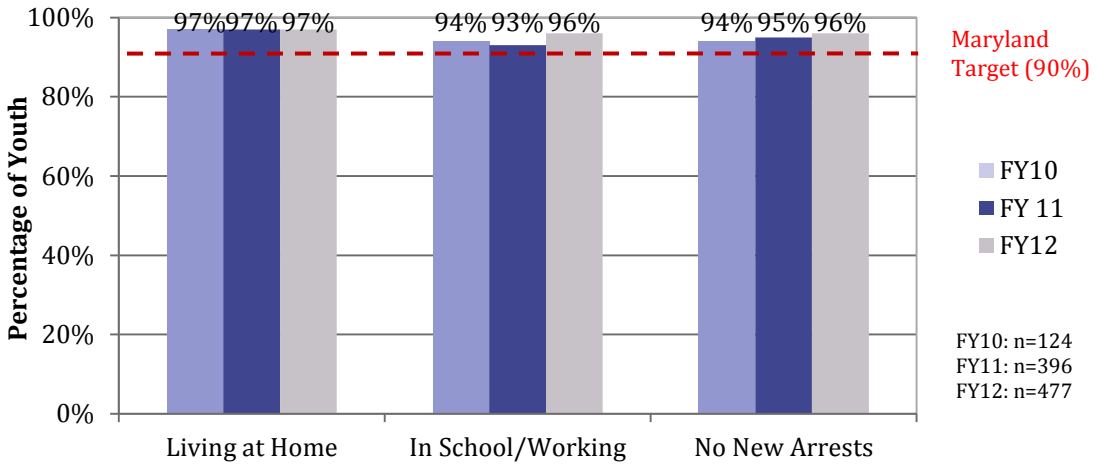
Factor	Shorter LOS	Longer LOS
Age at Admission	15 years and older (122.6)	Under 15 years old (136.8)
Prior Referrals to DJS	Yes (121.2)	No (156.8)
Prior DJS Commitments	Yes (107.2)	No (130.9)
Funding Source	DJS (118.9)	DSS (145.6) GOC/CCIF (162.2)

Ultimate Outcomes at Discharge

Even though most youth completed FFT, it does not mean that the program was effective for everyone. Three measures of success constitute the *ultimate outcomes* that are closely monitored by providers: (1) whether the youth was living at home at discharge, (2) whether the youth was in school and/or working at discharge, and (3) whether the youth had been arrested for a new offense since treatment had started. Other indicators of success include post-discharge outcomes, which are discussed in the next section.

Figure 17 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; this goal has been achieved in each of the three years. Further, 91% of completers in FY12 had positive results for all three outcomes. Success for all three outcomes was significantly more likely for youth who did not have previous involvement with DSS and for those with a shorter length of stay. Gender, race/ethnicity, age at admission, and prior DJS involvement were not statistically related to this successful outcome.

Figure 17. Ultimate Outcomes at Discharge for Youth who Completed FFT, FY10-FY12



DJS Involvement during Treatment

Readers should note that the ultimate outcomes are reported by FFT therapists, who may not be aware of all youth contacts with law enforcement or the justice system. Further, not all contacts with the juvenile justice system may be the result of an arrest—youth may also be referred to DJS from other sources (e.g., school). According to DJS data, 21% of youth had been referred to DJS while receiving FFT in FY12 (of completers)—compared with the reported 4% who had new arrests upon discharge. In addition, DJS data show that 11% of youth were admitted to a DJS detention facility during treatment.

Longitudinal Outcomes

Subsequent Involvement with the Juvenile Justice System

Research has demonstrated that participation in FFT is associated with a reduced risk for delinquency and criminal behavior. In order to assess longitudinal outcomes in Maryland, The Institute provided DJS with the name, gender, race/ethnicity, and date of birth of *all* youth who were discharged from FFT in FY10 and FY11, in order to identify matches in DJS's automated case management system (ASSIST). Subsequent involvement with the juvenile justice system during the follow-up period was categorized as referred to DJS, adjudicated delinquent, and committed to DJS (see the insert for definitions). Youth who

had been placed in a secure residential facility (e.g., detention, Youth Center) as of discharge from FFT were excluded from the analysis (two youth in FY10 and seven youth in FY11).

The majority of youth who completed FFT in FY10 and FY11 avoided subsequent contact with DJS within one year of discharge (Figure 18). Of the 122 youth followed from FY10, 30% were referred to DJS, with 14% subsequently adjudicated delinquent, and 7% committed to DJS. Of the 389 youth discharged in FY11, 35% were referred to DJS (26, or 7%, for a felony offense), 13% were adjudicated delinquent, and 6% were committed during the one-year follow-up period.

According to bivariate analyses using FY11 discharges, males, younger youth, and those with a prior DJS referral were significantly more likely to be referred to DJS within one year post FFT discharge. Youth who were successful for all three ultimate outcomes were significantly less likely to be referred to DJS. Race/ethnicity, having a prior DJS commitment, and prior DSS involvement were not related to having a subsequent DJS referral.

DJS Involvement/Recidivism Measures

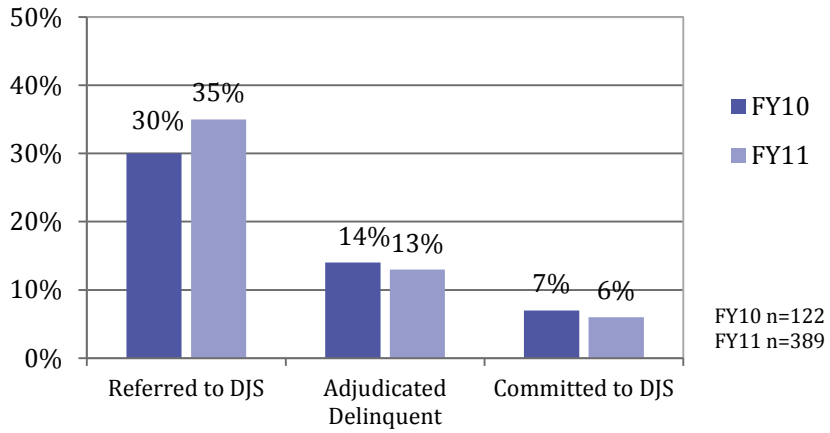
Referred to DJS refers to a referral to DJS for a delinquent offense.

Adjudicated delinquent refers to any youth who has a judiciary hearing and is adjudicated delinquent for an offense occurring post-discharge.

Committed to DJS refers to any youth who is committed to DJS custody for placement for an offense occurring post-discharge.

Note: Criminal justice system (adult) data were not available during the preparation of this report. These data have been requested and will be included in a future version.

Figure 18. DJS Involvement within 12 Months Post-Discharge, Youth who Completed FFT, FY10 & FY11

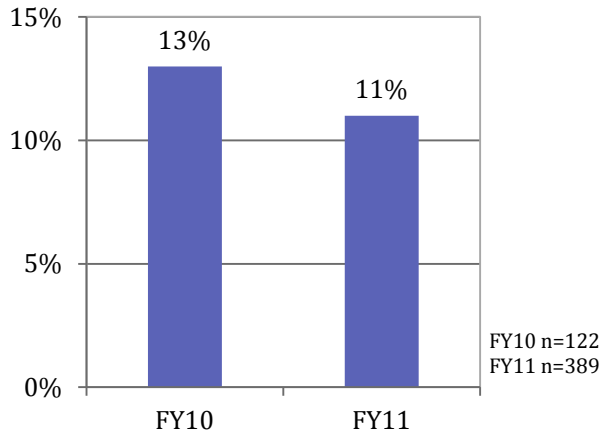


New Residential Placement with Juvenile Services. Youth who are committed to DJS do not need to commit a new offense and be processed through the juvenile court in order to be placed in a residential facility. Consequently, more youth may be admitted to a new residential placement following discharge from FFT than indicated by rates of commitment (shown above). Conversely, not all commitment orders will result in the youth residing in an out-of-home placement. Of the 122 youth who completed FFT in FY10, 13% were admitted to a residential placement[4] by DJS during the twelve months following

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

discharge (Figure 19). By comparison, of the 389 youth who completed FFT in FY11, 11% were admitted to a residential placement in the year following discharge. The most frequent types of placements included in-patient substance abuse programs, Youth Centers, secure facilities, and group homes. Note that these percentages do not include youth who were residing in a secure facility at discharge from FFT (see above).

Figure 19. New DJS Residential Placement within 12 Months Post-Discharge, Youth who Completed FFT, FY10 & FY11



Subsequent Involvement with the Child Welfare System

The Institute also provided DHR with the names, dates of birth, and other demographic variables of all youth who were discharged prior to the last day of FY11. DHR matched these youth in their state SACWIS (State Automated Child Welfare Information System) system known as CHESSIE (Children's Electronic Social Services Information Exchange) to retrieve information about contact with the child welfare system post-FFT discharge. As per DHR data, of the 124 youth who completed FFT in FY10, only one (<1%) was placed out-of-home within twelve months of discharge (none received in-home services). Of the 396 youth who completed in FY11, seven (2%) were placed out-of-home, five (1%) began receiving in-home services, and two (<1%) had new DSS investigations within twelve months of discharge from FFT.

What FFT has meant to families in Maryland: Brittany's Story

Brittany and her mother were referred to FFT in 2011. She had been referred to DJS after she stole from a local grocery store. When Brittany started FFT, her relationship with her mother was not strong, she was not attending school on a regular basis, she was involved in an abusive relationship, and she was not following house rules.

Brittany did not want the therapist to meet with her and her mother because she felt there was nothing wrong and things would always be the same at home. As weeks passed, Brittany started trusting the therapist, enabling her to work with her mother on their relationship.

By the end of FFT, Brittany had graduated from high school, found full-time employment, and improved her communication and relationships with her mom and sister. Brittany and her mother are still in contact with the therapist, and DJS has closed her case.

FY12 FFT Implementation in Maryland: Successes & Challenges

Utilization

- The percentage of referred youth who started FFT increased in FY12, and the percentage of ineligible referrals declined, suggesting better communication among referral sources and providers.
- Approximately 180 youth did not start FFT because the youth or family did not consent to treatment or they were unavailable. Greater effort should be expended to educate parents on the goals of the program, encourage participation, and work with parents to ensure that the program suits their circumstances.
- The average utilization rate for funded FFT slots was 71%, and 79% for active slots. Although improving over the year, utilization continues to fall under the 90% target for the state.
- The global admission length has generally declined over time, and, on average, youth and families started treatment within three weeks of referral during FY12. There are, however, significant differences in global admission length between DJS- and CCIF-funded slots, warranting a closer look into possible differences in the process.
- A diverse population of girls and boys from different racial and ethnic backgrounds were referred and admitted to FFT. However, there has been an identified need for more availability of Spanish-speaking therapists to better serve Spanish-speaking families.

Fidelity

- Both the *Average Fidelity Score* and the *Average Dissemination Adherence Score* have increased from FY11 to FY12; in both cases the average score exceeded the FFT national target.
- The average length of stay in treatment has generally declined over the past few years, but still exceeds the target of three to four months for youth who complete treatment.

Outcomes

- Approximately three-quarters of discharged youth completed treatment in FY12, which represents a notable improvement as compared with discharge cohorts from the previous two fiscal years. However, significantly fewer African-American/Black youth completed treatment relative to Caucasian/White youth; reasons for these results should be explored.
- For a third year in a row, youth who completed FFT have exceeded the target goal of 90% on each of the ultimate outcomes (i.e., living at home, in school/working, and no new arrests at discharge), and 91% achieved success for all three of the outcomes as of discharge.
- There were a higher percentage of referrals to DJS during the twelve months post-discharge among the FY11 completers relative to FY10 completers, but the former group also had lower percentages of being adjudicated delinquent, committed to DJS, and placed in a committed residential facility.
- Very few youth who completed FFT in FY11 (3%) had new involvement with DSS in the year following discharge.

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