Evidence-based Intervention Programs
FY 2012/2013 Outcomes Report
A summary of economic and youth impact, trends and recommendations

Prepared for the Pennsylvania Commission on Crime and Delinquency
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The EPISCenter represents a collaborative partnership between the Pennsylvania Commission on Crime and Delinquency (PCCD), and the Prevention Research Center, College of Health and Human Development, Penn State University. The EPISCenter is funded by PCCD and the Department of Public Welfare. This resource was developed by the EPISCenter through PCCD grant VP-ST-24368.
Executive Summary

The Evidence-based Prevention and Intervention Support Center (EPISCenter) is tasked with collecting data on program utilization, implementation quality, and youth outcomes for Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST), and Functional Family Therapy (FFT) programs across the Commonwealth. As a group, these three programs are referred to as Evidence-based Interventions (EBIs), because they provide treatment youth already exhibiting behavior problems.

All providers of these Blueprint Model programs receive funding from the state and are expected to participate in the statewide data collection process. State funding for EBIs includes Special Grants or Human Services Block Grants provided to counties by the Pennsylvania Department of Public Welfare’s Office of Children Youth and Families, grants from the Pennsylvania Commission on Crime and Delinquency, and Medical Assistance.

Data collected and submitted to the EPISCenter represent the vast majority of teams providing EBI services and includes all youth served regardless of funding source. The present report highlights data collected through the INSPIRE system during Fiscal Year 2012/2013 and includes data from Fiscal Year 2011/2012 for comparison.

Cost Savings Associated With the Use of EBIs

Data suggests significant costs savings associated with Pennsylvania’s use of these three EBIs:
- There is an estimated immediate cost savings of $10 million related to diversions from placement in FY 2012/2013.
- Based on all youth discharged in FY 2012/2013, the total economic benefit associated with crime reduction is estimated at $56.9 million.

The Population Served:

EBI programs in Pennsylvania serve many high risk youth involved with county systems.
- 2,540 new youth were enrolled in the evidence-based interventions (EBIs) during FY 2012/2013.
- Across all three programs, the vast majority of referrals came from the child welfare and juvenile justice systems.
- Over 1,250 (49%) youth enrolled in an EBI during FY 2012/2013 were at imminent risk of placement at the time of enrollment or stepping down from an out-of-home placement, according to provider reports.
Outcomes Achieved
Among clinically discharged youth1:

- Using stringent and program-specific definitions of success, the majority of youth were discharged successfully (FFT-73%; MST-74%; MTFC-67%). All three programs saw an increase in the rate of successful discharge from the previous year.
- At the point of discharge, rates of recidivism were low and the majority of youth remained in the community. Only 241 youth (11%) were placed at discharge.
- Follow-up data is limited but suggests that rates of recidivism and placement remain low 6-months post-discharge.

Fewer Youth Are Being Referred to EBIs
While EBIs positively impact the youth and families served and generate a significant cost-savings for the Commonwealth, the number of youth enrolled has decreased 19% over the past three years. Low utilization threatens the future of many EBI teams.

- In FY 2012/2013, FFT was used at 76% of its existing capacity.
- At the end of Quarter 4, 56% of MST teams had average caseloads below model requirements and below sustainable levels.
- MTFC was used at about 20% of capacity. Since July 1, 2012, three of five MTFC sites have closed or are in the process of closing.

Sustainability Initiatives
Over the past year, two significant initiatives have attempted to address the sustainability challenges faced by EBI programs.

- The Pennsylvania Commission on Crime and Delinquency offered Bridge Funding Grants in an effort to provide sites with some financial relief while they worked to implement sustainability plans. Awards began October 1, 2013, and are coupled with intensive technical assistance from the EPISCenter.
- Since November 2012, EBI providers have come together to address their shared challenges. This has included “sustainability calls” to prioritize barriers and strategize, but the most significant impact has come from providers developing individualized strategies for their sites.

Past Recommendations & Current Progress
In its December 2012 report, “Looking Back, Moving Forward”, the EPISCenter shared strategies for success and made a number of recommendations for providers, local stakeholders, and state agencies, aimed at addressing barriers to program sustainability. Over the past year, many providers have implemented strategically-designed interventions aimed at targeting key barriers and improving sustainability. The EPISCenter has intensified its outreach to local stakeholders in an effort to increase awareness of ways that counties can benefit from and support sustainability. At this time it is unclear to what extent recommendations regarding

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1 Administrative discharges are excluded from clinical discharges. Administrative discharges include youth discharged prior to completing the program for non-clinical reasons that are outside of the program’s control (e.g., the family moves, loss of funding, youth is placed for an event that occurred prior to program enrollment).
state-level action have been taken into consideration. An updated set of recommendations is offered in Appendix B.

Conclusion
Since the first FFT site was established in Pennsylvania in 1999, the Commonwealth has invested more than $35 million in evidence-based interventions\(^2\). EBIs across the Commonwealth have demonstrated high rates of treatment completion and positive outcomes for the majority of youth served, resulting in significant cost savings for Pennsylvania taxpayers. However, utilization of these Blueprint Model Programs has decreased over the past few years while costs have increased, posing a significant threat to the program sustainability and the availability of evidence-based programming for high risk adolescents in the state.

Many EBI providers have devoted extensive resources over the past year to making their programs more sustainable, and several of the recommendations made in the December 2012 report “Looking Back, Moving Forward” have been followed, with some positive results. However, the future remains uncertain for these programs. The stability of EBIs could be greatly enhanced through policies and funding mechanisms that create an “EBI-friendly” environment.

\(^2\) This includes over $17 million in EBP grants awarded by PCCD from 1999-2008 for the start-up of FFT, MST, and MTFC, and over $18 million in Special Grant expenditures (funds given to counties by the Office of Children, Youth, and Families) from 2008-2013. PCCD Category 3 grant awards and Medical Assistance dollars are not included.
Evidence-based Intervention Programs:
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Multisystemic Therapy

Overview of Youth Enrolled & Discharged
Referral Sources
MST Outcomes at Discharge
MST Outcomes 6 Months Post-Discharge
Implementation Quality: MST

Multidimensional Treatment Foster Care

Overview of Youth Enrolled & Discharged
Referral Sources
MTFC Outcomes at Discharge
MTFC Outcomes 6 Months Post-Discharge
Implementation Quality: MTFC

Utilization Trends

From FY 2011/2012 to FY 2012/2013
Quarterly Trends for 2012/2013

Sustainability Initiatives

Bridge Funding
Guiding Provider Sustainability Efforts

Prior Recommendations & Current Progress

Conclusion

Reference
Evidence-based Intervention Programs: FY 2012/2013 Outcomes Summary

Introduction

The Evidence-based Prevention and Intervention Support Center (EPISCenter) is tasked with collecting data on program utilization, implementation quality, and outcomes for Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST), and Functional Family Therapy (FFT) programs across the Commonwealth. As a group, these three programs are referred to as evidence-based interventions (EBIs), because they provide treatment youth already exhibiting behavior problems.

State funding for EBIs includes Special Grants or Human Services Block Grants provided to counties by the Pennsylvania Department of Public Welfare’s Office of Children Youth and Families, Medical Assistance, and grants from the Pennsylvania Commission on Crime and Delinquency. In Pennsylvania, all providers of these Blueprint Model programs currently receive funding from the state and are therefore expected to participate in the statewide data collection process. Data presented in this report represents the vast majority of teams providing EBI services and includes all youth served regardless of funding source.

Quarterly and annual reports prepared by the EPISCenter are shared regularly the Steering Committee for the Pennsylvania Resource Center for Evidence-Based Prevention and Intervention Programs and Practices, which includes representation from a wide range of state agencies. The data included in these reports provides the Steering Committee with information about the utilization and impact of EBIs in Pennsylvania.

The present report:

- provides an overview of the three EBIs and their availability in Pennsylvania counties,
- highlights the impact of EBIs during Fiscal Year 2012/2013, including economic impact and outcomes for youth and families,
- discusses significant trends in the utilization of EBIs,
- reviews recent initiatives to improve sustainability, and
- makes recommendations for ensuring that Pennsylvania’s significant financial investment in these valuable services continues to provide a return on investment.

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3 PCCD grants funded the start up of many EBIs from 1999 to 2009. While FFT, MST, and MTFC have not been eligible for Evidence-based Program grants from PCCD since the 2008 request for proposals, five providers were recently awarded PCCD grants for Bridge Funding to help with sustainability.
Pennsylvania’s Resource Center for Evidence-Based Prevention and Intervention Programs and Practices has identified 11 evidence-based and promising programs for capacity building, technical assistance and outcomes monitoring. The present report focuses on three programs which provide intervention (treatment) to adolescents who have already exhibited significant behavior problems. A brief description of each program and its availability in Pennsylvania is provided below.

**Functional Family Therapy (FFT)**

**Target Population:** Youth ages 10-17 who present with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors to serious, chronic criminal offenses. FFT is especially suited to families with high conflict, ineffective parenting skills, and/or heavy system involvement.

**The Model:** FFT is an intensive, short-term family therapy model that views youth behavior as serving a function within the family. Therapy is typically conducted in the family’s home by a trained therapist. Sessions occur as frequently as necessary to meet the family’s needs and are typically provided over a period of three to five months. The FFT model is organized around phases of treatment that emphasize engaging and motivating the youth and family, facilitating change within the family, and generalization of changes.

**Targeted Outcomes:**
- Fewer out of home placements
- Reduced recidivism
- Improved family functioning
- Reductions in youth behavior problems, mental health symptoms, and substance use

**Program Structure:** Each FFT site is comprised of 3 to 8 clinicians, including a clinical site supervisor and Masters-level family therapists. A full-time therapist carries a caseload of 10-12 families.

**FFT Providers in Pennsylvania**

- TrueNorth Wellness Services (formerly Adams-Hanover Counseling Svc)
- Children’s Service Center
- The Consortium
- Family Intervention Crisis Services
- Family Services of NW PA
- Intercultural Family Services
- Nulton Diagnostic & Treatment Center
- Valley Youth House
- VisionQuest

FY 2012/2013
Multisystemic Therapy (MST)

Target Population: Adolescents age 12-17 with significant externalizing behaviors. The primary treatment population is delinquent youth and chronic or violent juvenile offenders.

The Model: Treatment focuses on changing aspects of the youth’s environment (home, school, peers, and community) that contribute to or maintain the identified problem behaviors, with an emphasis on empowering caregivers and developing their skills to effectively manage the youth. MST also includes frequent collaboration with other systems with which the youth is involved. Treatment takes place in the youth’s home, school and community. MST is an intensive, short-term treatment, typically lasting 3 to 5 months, with therapists offering around-the-clock crisis coverage.

Targeted Outcomes:
- Fewer days in placement
- Reduced recidivism
- Improved family & peer relationships
- Decreases in behavior problems & substance use

Program Structure:
An agency may have one or more MST teams, consisting of an MST Supervisor and 2 to 4 Bachelor or Masters-level therapists who cover a specific service area and meet weekly for group supervision. Each therapist carries a caseload of 4 to 6 youth at a time.

MST Providers in Pennsylvania:
- Adelphi Village (10 teams)
- Beacon Light (2 teams)
- Child Guidance Resource Center (4 teams)
- Community Solutions, Inc. (9 teams)
- Cray Youth & Family Services (1 team)
- Family Services of NW PA (2 teams)
- Harborcreek Youth Services (2 teams)
- Hempfield Behavioral Health (3 teams)
- Home Nursing Agency (1 team)
- K/S-MST (5 teams)
- Lourdesmont (1 team)
- MHY Family Services (5 teams)
- Pennsylvania Counseling Svcs (3 teams)
- Wordsworth (1 team)

Five teams are trained to provide MST for Problem Sexual Behavior. This includes all three Hempfield Behavioral Health teams and the Family Services of NW PA team in Erie county, which offer both traditional MST and MST-PSB, and the team at Wordsworth in Philadelphia, which provides MST-PSB exclusively.

FY2012/2013
Multidimensional Treatment Foster Care (MTFC)

Target Population: Youth ages 12-17 with chronic and severe antisocial behavior, possibly with complex co-morbid conditions. MTFC is an alternative to congregate care placements such as residential treatment, detention, and group homes.

The Model: Youth are placed in a family setting for six to nine months during which time the youth and his/her identified aftercare family receive treatment from a team consisting of a program supervisor, a family therapist, an individual therapist, a child skills trainer, a daily caller/treatment parent trainer/recruiter, and treatment parents. The youth receives weekly individual therapy and skills coaching, while the aftercare family participates in weekly family therapy to prepare for the youth’s transition home. Treatment parents are recruited, trained, and supported as an essential part of the treatment team. Treatment parents provide mentoring, a supervised and structured home environment, effective behavior management, and daily feedback to the rest of the team regarding the youth’s behavior. Treatment parents participate in weekly group meetings that provide them with support and enhance treatment planning.

Targeted Outcomes:
- Improved treatment stability and fewer days out of home
- Reduced recidivism and rates of incarcerations
- Improved mental health and reduced substance use
- Improved school functioning

Program Structure:
An MTFC team (described above) can serve up to 10 youth at a time. Only one youth is placed per home. MTFC programs in Pennsylvania are dually licensed as CRR Host Home Programs (mental health license) and foster homes (child welfare license).

MTFC Providers in Pennsylvania:
- Children’s Home of York
- NHS Delaware
- Children’s Home of Reading – Cumberland/Dauphin site (Jan. 2013)
- Children’s Home of Reading – Lehigh Valley site (Sept. 2013)
- Venango Children and Youth Services (Feb. 2013)

Now Closed

FY 2012/2013
EBI Availability in Pennsylvania, FY 2012/2013

<table>
<thead>
<tr>
<th></th>
<th>FFT</th>
<th>MST</th>
<th>MTFC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>9</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Sites/Teams</td>
<td>9</td>
<td>49</td>
<td>5</td>
</tr>
<tr>
<td>Counties Served</td>
<td>12</td>
<td>56</td>
<td>9</td>
</tr>
<tr>
<td>New Teams Began</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Teams Closed</td>
<td>0</td>
<td>3(^4)</td>
<td>2</td>
</tr>
<tr>
<td># of Youth Served</td>
<td>1,297</td>
<td>2,045</td>
<td>26</td>
</tr>
</tbody>
</table>

The maps below illustrate the availability of each EBI across the Commonwealth in 2012/2013. The relative capacity in each county is reflected by the color of the county. Gray counties had no existing capacity for the service in 2012/2013. Lighter colors reflect relatively small capacity while darker colors reflect larger capacity. (Capacity is defined as the number of youth that could potentially be served, based on the size of the program in that county.) More detailed information about the location of current EBI programs is available on the EPISCenter website.

Functional Family Therapy

\(^4\) In all cases, the counties served by closed teams continued to be served by another, already existing team.
Evidence-based Intervention Programs:
FY 2012/2013 Outcomes Summary

Economic Benefits of Evidence-based Intervention

Savings from Placement Diversions
In addition to improved outcomes for youth and families, evidence-based interventions (EBIs) offer significant economic benefits. One potential area of cost savings is the immediate savings associated with fewer youth going into expensive out-of-home placements.

For youth clinically discharged from EBIs in FY 2012/2013, an estimated 1,381 youth were at high risk of placement upon admission, but only 241 were discharged from intervention programs to restrictive, out-of-home placement. This translates into an estimated cost savings of $10 million in a single year, related to diversions from placement across the three programs.

Cost savings related to placement diversion was calculated using a formula that compared potential placement costs to the actual cost of offering EBIs to a large number of youth, including some not at immediate risk of placement, and still placing those who were unable to remain in the community:

- First, we determined the number of youth enrolled in EBIs who were at high risk of placement upon admission\(^5\), and calculated the estimated cost of placing these youth for 90 days in the juvenile justice system\(^6\), rather than using EBIs. This is Potential Placement Costs.

<table>
<thead>
<tr>
<th></th>
<th>FFT</th>
<th>MST</th>
<th>MTFC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Clinical Discharges</td>
<td>761</td>
<td>1334</td>
<td>18</td>
<td>2,113</td>
</tr>
<tr>
<td>Percent at Risk of Placement</td>
<td>42.5%</td>
<td>78.1%</td>
<td>88.2%</td>
<td>65.4%</td>
</tr>
<tr>
<td>Number of Clinical Discharges at Risk of Placement (#clinical discharges x percent at risk)</td>
<td>323</td>
<td>1042</td>
<td>16</td>
<td>1381</td>
</tr>
<tr>
<td>Placement Cost Per Youth</td>
<td>$24,777</td>
<td>$24,777</td>
<td>$24,777</td>
<td>$24,777</td>
</tr>
<tr>
<td><strong>Potential Placement Costs (# at risk x placement cost per youth)</strong></td>
<td><strong>$8,002,971</strong></td>
<td><strong>$25,817,634</strong></td>
<td><strong>$396,432</strong></td>
<td><strong>$34,217,037</strong></td>
</tr>
</tbody>
</table>

\(^5\) For the purpose of this analysis, placement risk of youth for whom risk information was missing was extrapolated based youth for whom placement risk was reported. For example, 184 of 433 (42.5%) youth clinically discharged from FFT were stepping down from placement or at immediate risk of placement at enrollment. Placement risk was missing for 328 youth; the number of those youth who were at risk was estimated using 42.5%.

\(^6\) Estimated savings from placement diversion is based on data available at the time of this report. Placement cost per youth is based on median per diem for institutional juvenile justice placements in FY 2011/2012 ($275.30) and a conservative estimate of 90 days.
Second, we calculated the estimated cost of using EBIs in Pennsylvania using a two-step approach. 1) For each EBI, *Actual Program Costs* was estimated by multiplying the number of youth clinically discharged by the average cost for a full course of treatment.\(^7\) 2) Because not all placement diversions are successful, we also considered the cost of placement for those youth who did not remain in the community. The number of youth discharged to restrictive, out-of-home placements was multiplied by the cost of placement to estimate *Actual Placement Costs*. These two costs were summed to obtain the *Actual Program + Placement Costs*.

<table>
<thead>
<tr>
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<td>1334</td>
<td>18</td>
<td>2,113</td>
</tr>
<tr>
<td>EBI Cost Per Youth(^7)</td>
<td>$3,909.46</td>
<td>$10,661.03</td>
<td>$53,056.06</td>
<td>---</td>
</tr>
<tr>
<td><strong>Actual Program Costs</strong></td>
<td><strong>$2,975,099</strong></td>
<td><strong>$14,221,814</strong></td>
<td><strong>$955,009</strong></td>
<td><strong>$18,151,922</strong></td>
</tr>
<tr>
<td>Number of Youth Placed at Discharge</td>
<td>76</td>
<td>161</td>
<td>4</td>
<td>241</td>
</tr>
<tr>
<td>Placement Cost Per Youth</td>
<td>$24,777.00</td>
<td>$24,777.00</td>
<td>$24,777.00</td>
<td>$24,777.00</td>
</tr>
<tr>
<td><strong>Actual Placement Costs</strong></td>
<td><strong>$1,883,052</strong></td>
<td><strong>$3,989,097</strong></td>
<td><strong>$99,108</strong></td>
<td><strong>$5,971,257</strong></td>
</tr>
<tr>
<td><strong>Actual Program + Placement Costs</strong></td>
<td><strong>$4,858,151</strong></td>
<td><strong>$18,210,911</strong></td>
<td><strong>$1,054,117</strong></td>
<td><strong>$24,123,179</strong></td>
</tr>
</tbody>
</table>

Finally, the difference between *Potential Placement Costs* and *Actual Program + Placement Costs* was calculated, providing the *Net Savings from Placement Diversion*.

<table>
<thead>
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</tr>
<tr>
<td><strong>Total Net Savings</strong></td>
<td><strong>$3,144,820</strong></td>
<td><strong>$7,606,723</strong></td>
<td><strong>-$657,685</strong></td>
<td><strong>$10,093,858</strong></td>
</tr>
</tbody>
</table>

For MTFC, actual costs were estimated to be greater than the cost of placing youth who were at risk. This may be due to 1) a very conservative estimate of length of stay for placement (90 days for the comparison placement versus an average length of stay in MTFC of 210 days for youth completing treatment), and 2) the number of youth served being too low to “tip the balance” in

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\(^7\) Program cost per youth is based on average across providers or sites for each program, using the average BH-MCO rate as reported by providers in a [March 2012 Rate Survey](#) and average length of stay for completed cases in FY 2012/2013. For MTFC, program cost includes room and board.
favor of evidence-based placement. Even with a small number of youth served, the estimated economic benefit in terms of crime reduction is significant, as described in the next section.

Further information about the impact of EBIs in Pennsylvania on placement rates can be found on the EPISCenter website.

**Statewide Placement Trends & the Relationship to EBIs**

Youth placement rates in Pennsylvania have been decreasing over the past several years, as a number of initiatives and strategies to keep youth in their homes and communities have been rolled out across the Commonwealth. One way to evaluate the potential impact of evidence-based interventions on placement rates is to compare trends in counties that adopted an EBI to those that did not.

We identified a group of 19 counties that did not have an EBI in place in 2006, then divided this group into two cohorts – one that adopted FFT or MST between 2007 and 2009\(^8\) (Cohort A, 11 counties) and those that did not (Cohort B, 8 counties). This allows us to look at the change in placement rates following the adoption of an in-home, evidence-based treatment program within a subset of communities.

It should be noted that Cohort A and B may differ on other dimensions, besides the adoption of EBIs. For instance:
- **The two cohorts may also differ in their adoption of other initiatives and strategies to reduce placement rates. The fact that Cohort A exhibited decreasing placement rates even prior to adopting an EBI supports this assertion.**
- **Cohort A includes a larger population of youth and in 2006 was placing a higher number of youth than Cohort B in 2006. Adoption of EBIs may have been influenced by a greater need for placement alternatives.**
- **Within each cohort, there was variability across counties in the rate and direction of placement change from 2006 to 2012.**

Comparison of placement trends in the two cohorts ends with 2012, when four of the eight counties in Cohort B initiated FFT or MST.

**Across all placement types, the cohort of counties adopting an EBI showed steeper declines in the number of youth being placed out of home, compared to the cohort of counties without in-home evidence-based services.**

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\(^8\) Within Cohort A, one county began implementation in 2007, two in 2008, and eight in 2009.
Juvenile Justice Placement Trends

Chart 12: Juvenile Justice Placement Rates, 2006-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Statewide</th>
<th>Cohort A (adopted EBI)</th>
<th>Cohort B (did not adopt EBI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>10.30%</td>
<td>10.69%</td>
<td>10.58%</td>
</tr>
<tr>
<td>2007</td>
<td>9.89%</td>
<td>9.89%</td>
<td>9.07%</td>
</tr>
<tr>
<td>2008</td>
<td>9.55%</td>
<td>8.70%</td>
<td>9.76%</td>
</tr>
<tr>
<td>2009</td>
<td>8.46%</td>
<td>7.79%</td>
<td>10.05%</td>
</tr>
<tr>
<td>2010</td>
<td>8.73%</td>
<td>7.91%</td>
<td>10.58%</td>
</tr>
<tr>
<td>2011</td>
<td>7.99%</td>
<td>7.55%</td>
<td>9.50%</td>
</tr>
<tr>
<td>2012</td>
<td>8.05%</td>
<td>6.52%</td>
<td>10.15%</td>
</tr>
</tbody>
</table>

The graph and table above show placements as a percent of total dispositions (new allegations and reviews; disposition reviews not included).

- Statewide, the juvenile justice placement rate decreased from 10.30% in 2006 to 8.05% in 2012.
- The placement rate of Cohort A mirrored this trend, with a decrease from 10.69% of dispositions resulting in placement in 2006 to 6.52% in 2012.
- The cohort of counties that did not adopt an EBI during that time period showed a more erratic pattern and only a slight decrease overall, with a .43% difference between 2006 and 2012. This change was much smaller than the decrease in Cohort A (4.17%) and the state as a whole (2.25%) over the same period of time.
Changes in the raw number of delinquency placements were also examined. As shown in the table above, the number of placements decreased consistently from 2006 to 2012 for the state as a whole as well as for Cohort A. The decrease was more dramatic for Cohort A, which showed a 46% reduction in the number of placements compared to a 30% decrease statewide.

In contrast, the number of placements by Cohort B lacked a consistent trend over the 7 years examined. The 16% change from 2006 to 2012 was in the positive direction, but less dramatic.

**Child Welfare Placement Trends**

![Chart 13: Child Welfare Placement Rates for Youth 10-17 Years Old, 2006-2013](chart.png)
Evidence-based Intervention Programs: FY 2012/2013 Outcomes Summary

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>41.09%</td>
<td>41.38%</td>
<td>39.54%</td>
<td>39.20%</td>
<td>40.43%</td>
<td>38.68%</td>
<td>38.76%</td>
<td>42.25%</td>
</tr>
<tr>
<td>Cohort A</td>
<td>35.30%</td>
<td>36.13%</td>
<td>32.36%</td>
<td>32.38%</td>
<td>32.38%</td>
<td>31.98%</td>
<td>35.02%</td>
<td>--</td>
</tr>
<tr>
<td>Cohort B</td>
<td>30.88%</td>
<td>29.48%</td>
<td>32.55%</td>
<td>31.99%</td>
<td>35.56%</td>
<td>37.90%</td>
<td>35.78%</td>
<td>--</td>
</tr>
</tbody>
</table>

The chart and graph above show the percent of youth ages 10-17 who were in care on March 31 of each year, who were in a congregate placement (e.g., institution, group home).

- While the percent of youth in congregate care statewide generally decreased during the time period examined, there was a large increase from 2012 to 2013, resulting in placement rates higher than those seen in 2006.
- While Cohort A saw decreasing placement rates from 2007 to 2011, while Cohort B showed increases, placement rates for the two cohorts began to converge when the placement rate for Cohort A showed an unexpected increase in 2012. Interestingly, statewide placements showed a similar increase the following year, with the highest placement rate in eight years.

One explanation for the increase statewide and the convergence of the two cohorts may be the decrease in the number of youth in care overall. As counties work to reduce the number of youth being removed from their homes, the youth placed out of home are likely to be those with the most significant needs. The lower number of adolescents in care (highlighted in the table below) is likely reflective of a number of initiatives, including the use of evidence-based interventions to address family relationships, parenting, and youth behavior so that out-of-home placement can be avoided. Another possibility is that decreased utilization of EBIs over the past few years, in spite of wider availability, has resulted in a rebound in the rate of placement.

<table>
<thead>
<tr>
<th>Number of Dependent Youth, Ages 10-17, In Congregate Care</th>
<th>205106</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>% change 2006 to 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>5,001</td>
<td>4,777</td>
<td>4,114</td>
<td>3,644</td>
<td>3,025</td>
<td>2,557</td>
<td>2,398</td>
<td>-52%</td>
</tr>
<tr>
<td>Cohort A</td>
<td>854</td>
<td>826</td>
<td>644</td>
<td>567</td>
<td>465</td>
<td>421</td>
<td>474</td>
<td>-51%</td>
</tr>
<tr>
<td>Cohort B</td>
<td>155</td>
<td>143</td>
<td>152</td>
<td>135</td>
<td>128</td>
<td>130</td>
<td>117</td>
<td>-25%</td>
</tr>
</tbody>
</table>

Considering changes in the raw number of dependent youth placed in congregate care, Cohort A showed a 51% decrease in the number of youth placed, paralleling the statewide trend, while Cohort B showed a more modest decrease of 25%.
Mental Health Placement Trends
Lastly, while placement rates for Medical Assistance-funded congregate care placements were not available, the raw number of placements in residential treatment facilities and group homes with M.A. funding was examined. Similar to the pattern found in child welfare placements, the state as a whole and Cohort A saw comparable decreases of about 1/3, while Cohort B saw a more modest decrease of 9%.

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>% change 2006 to 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>6,236</td>
<td>6,117</td>
<td>5,421</td>
<td>4,650</td>
<td>4,056</td>
<td>4,198</td>
<td>Not available</td>
<td>-33%</td>
</tr>
<tr>
<td>Cohort A</td>
<td>1,072</td>
<td>1,059</td>
<td>884</td>
<td>761</td>
<td>729</td>
<td>737</td>
<td>Not available</td>
<td>-31%</td>
</tr>
<tr>
<td>Cohort B</td>
<td>247</td>
<td>310</td>
<td>247</td>
<td>230</td>
<td>217</td>
<td>253</td>
<td>Not available</td>
<td>-9%</td>
</tr>
</tbody>
</table>

Savings Associated with Future Crime Reductions
Many evaluations of the effectiveness of MTFC, MST, and FFT have demonstrated reductions in future criminal offenses and recidivism for youth who participate in these programs as compared to youth who do not participate. Therefore, another economic benefit is related to the potential longer-term savings associated with reductions in crime, including savings related to costs to victims and costs of crime (incarceration, etc.).

The estimated economic benefit related to crime reduction associated with these programs for FY 2012/2013 was calculated based on the 2012 estimated cost-benefit from the Washington State Institute of Public Policy9 (see Table on next page).

Based on all youth clinically discharged from one of these programs in FY 2012/2013, the total economic benefit associated with future crime reduction is estimated at $56.9 million.

---

### Evidence-based Intervention Programs: FY 2012/2013 Outcomes Summary

<table>
<thead>
<tr>
<th>Program</th>
<th>Benefit-Cost per Youth</th>
<th>Clinical Discharges FY 2012/2013</th>
<th>Estimated Economic Benefit (crime reduction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT</td>
<td>$30,706</td>
<td>761</td>
<td>$23,367,266</td>
</tr>
<tr>
<td>MST</td>
<td>$24,751</td>
<td>1,334</td>
<td>$33,017,834</td>
</tr>
<tr>
<td>MTFC</td>
<td>$31,276</td>
<td>18</td>
<td>$562,968</td>
</tr>
<tr>
<td>TOTAL</td>
<td>---</td>
<td>2,113</td>
<td>$56,948,068</td>
</tr>
</tbody>
</table>

If we take a more conservative approach and only include youth successfully discharged during that same period, the economic benefit associated with reductions in future crime is still over $41 million.

<table>
<thead>
<tr>
<th>Program</th>
<th>Benefit-Cost per Youth</th>
<th>Successful Discharges FY 2012/2013</th>
<th>Estimated Economic Benefit (crime reduction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT</td>
<td>$30,706</td>
<td>554</td>
<td>$17,011,124</td>
</tr>
<tr>
<td>MST</td>
<td>$24,751</td>
<td>984</td>
<td>$24,354,984</td>
</tr>
<tr>
<td>MTFC</td>
<td>$31,276</td>
<td>12</td>
<td>$375,312</td>
</tr>
<tr>
<td>TOTAL</td>
<td>---</td>
<td>1550</td>
<td>$41,741,420</td>
</tr>
</tbody>
</table>
Data Reporting Overview

Data from Evidence-based Intervention (EBI) programs across Pennsylvania is gathered and analyzed using a web-based data collection, integration, and reporting system called INSPIRE (INtegrated System for Program Implementation and Real-time Evaluation). EPISCenter shares quarterly and annual reports on statewide EBI implementation with the Steering Committee for the Pennsylvania Resource Center for Evidence-Based Prevention and Intervention Programs and Practices, which includes representation from a wide range of state agencies. Reports are also made available on the EPISCenter website and highlighted in the center’s newsletters and social media.

The present report highlights data collected through the INSPIRE system during Fiscal Year 2012/2013 and includes data from Fiscal Year 2011/2012 for comparison. Data includes information about the population served and outcomes, as well as implementation quality. Implementation quality includes therapists’ fidelity to the clinical model and adherence to programs and practices that are part of the evidence-based model. Multiple studies have demonstrated that high quality implementation increases the likelihood that youth receiving evidence-based interventions will have positive outcomes.

Data Source

As just noted, INSPIRE is a web-based data collection, integration, and reporting system developed by the EPISCenter to assist Pennsylvania’s Resource Center for Evidence-based and Promising Programs and Practices with evaluating the impact of evidence-based intervention programs across the Commonwealth.

INSPIRE was launched in spring 2011. INSPIRE generates a program highlights report using two sources of data:

- Data from each model’s national IT system, which is downloaded and integrated into INSPIRE on a regular basis. These data systems include the Client Services System for FFT, the MST Enhanced Website, and the WebPDR for MTFC.
- Enrollment, discharge, and follow-up data entered by providers directly into INSPIRE. This additional information cannot be obtained from the models’ IT systems, but is needed to generate outcomes of interest to the Resource Center.

Further information about INSPIRE can be found in the Frequently Asked Questions about INSPIRE on the EPISCenter website.

For overview, see MST Research At A Glance (January 2013), particularly Study #11, and the summary of change mechanism research available on the FFT Inc. website.
Comparing Outcomes across Programs

When comparing data across the three programs, readers should keep in mind the following:

- The populations served by each program vary and therefore outcomes may not be directly comparable across the three programs. While there is significant overlap in the populations served, particularly for FFT and MST, there may be overall differences in client risk factors and the severity of the population served.

- Definitions of success differ across the programs. “Success,” as defined for Pennsylvania’s performance measures, includes both completion of the program and achievement of certain goals identified by each model. The definitions of success used by Pennsylvania are considered very stringent. For instance, to be counted as successful a youth discharged from MST must achieve all three of the Ultimate Outcomes targeted by the model (i.e., youth is living at home, has no new criminal charges, and is attending school). For FFT, a youth must meet the threshold for satisfactory ratings on outcome measures completed by the youth, family, and therapist, although therapists can override these ratings if there is clinical evidence of positive outcome.

6-Month Follow-Up Outcomes

When reviewing follow-up data, please note the following limitations:

- At this time, limited information is available about the follow-up sample and the extent to which it reflects all youth clinically discharged from EBIs. Available data suggests that youth who have completed treatment are overrepresented in the follow-up sample. For instance, in FY 2012/2013, 83% of youth clinically discharged from MST completed treatment, whereas 98% of the follow-up sample completed. A similar pattern was found for FFT. This may skew results in a positive direction.

- Many EBI providers are not collecting follow-up data at this time. Therefore, follow-up data represents a limited subset of providers whose follow-up outcomes may not be representative of statewide outcomes.
Functional Family Therapy

Overview of Youth Enrolled & Discharged

<table>
<thead>
<tr>
<th></th>
<th>FY 2011/2012</th>
<th>FY 2012/2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sites reporting</td>
<td>10</td>
<td>9</td>
<td>-1</td>
</tr>
<tr>
<td>Total youth served</td>
<td>1,417</td>
<td>1,297</td>
<td>-120</td>
</tr>
</tbody>
</table>

**Youth Enrolled**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New youth enrolled</td>
<td>1,052</td>
<td>992</td>
<td>-60</td>
</tr>
<tr>
<td>Percent of youth enrolled who were at imminent risk of being placed in a more restrictive setting</td>
<td>33%</td>
<td>46%</td>
<td>+13%</td>
</tr>
</tbody>
</table>

**Youth Discharged**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of youth discharged</td>
<td>1,102</td>
<td>933</td>
<td>-169</td>
</tr>
<tr>
<td>Administrative withdrawal</td>
<td>13%</td>
<td>18%</td>
<td>+5%</td>
</tr>
<tr>
<td>Clinical discharge</td>
<td>87%</td>
<td>82%</td>
<td>-5%</td>
</tr>
</tbody>
</table>

**Average Length of Stay (in months)**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For youth completing treatment</td>
<td>3.9</td>
<td>4.2</td>
<td>+.3 months</td>
</tr>
<tr>
<td>For youth not completing treatment</td>
<td>2.7</td>
<td>3.2</td>
<td>+.5 months</td>
</tr>
</tbody>
</table>

More than half of the youth enrolled in FFT last year were from southeast Pennsylvania, primarily Philadelphia. There are three FFT providers serving Philadelphia and Chester counties.

- In FY 2012/2013, these providers served 48% (485 of 992) of youth enrolled in FFT.
- In FY 2011/2012, these three providers served 63% (666 of 1,052) of enrolled in FFT.

The 27% decrease in youth enrolled in FFT in southeast Pennsylvania, where 2 of 5 sites closed in spring 2012, was not seen elsewhere in the state. Statewide, enrollments decreased only 6%, as reduced utilization in the southeast combined with growth in other regions.

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11 Total number of youth discharged is a sum of successfully, unsuccessfully, and administratively withdrawn youth.
12 The category of administrative withdrawals is intended to capture youth discharged prior to completing the program for non-clinical reasons that are outside of the program’s control (e.g., the family moving, loss of funding, or the youth being placed for an event that occurred prior to program enrollment).
Youth Demographics

Two charts below highlight demographic information for the 992 youth enrolled in FFT in Fiscal Year 2012/2013. The average age of enrolled youth was 15.1 years.

Chart 1: Sex of Youth Enrolled in FFT

- Male: 37%
- Female: 63%

Chart 2: Race/Ethnicity for Youth Enrolled in FFT

- White: 43.2%
- Black/African-American: 40.8%
- Hispanic/Latino: 5.4%
- Multiracial: 10.1%
- Other Race or Ethnicity: 0.5%

13 “Other Race or Ethnicity” includes Asian (0.4%), Pacific-Islander (0.1%), and American-Indian (0.0%).
Referral Sources

The majority of referrals to FFT came from county agencies. While the distribution of referrals across sources was generally consistent from FY 2011/2012 to FY 2012/2013, there was an increase in the percent and number of referrals coming from child welfare (from 15% to 24% of total referrals), with a corresponding decrease in the percent and number of referrals coming from the juvenile justice system (53% decreasing to 41%).

Decrease in Juvenile Justice Referrals: This is likely due to a decrease in the number of youth enrolled in FFT in southeast Pennsylvania (primarily Philadelphia), where the majority of youth are referred by the justice system. Two Philadelphia sites closed in the spring of 2012 due to low utilization, and FY 2012/2013 saw a 28% decrease in the number of overall youth enrolled in FFT in this region (483 youth in FY 2012/2013, compared to 666 youth in FY 2011/2012).

Increase in Child Welfare Referrals: The change can be attributed to an increase in child welfare referrals to a subset of providers and a new provider who began offering FFT in July 2012. Three providers enrolled twice as many child welfare referrals in FY 2012/2013 compared to the previous fiscal year.

Chart 3: Referral Sources for Youth Enrolled in FFT
FFT Outcomes at Discharge

*For FFT, successful discharge is defined as completing the 3 phases of FFT and receiving average ratings of 3 or above (“somewhat better” to “very much better”) on outcome measures completed by youth, family, and/or therapist. Therapist may override low ratings, if there is clinical evidence of a positive outcome.

Chart 3: Treatment Outcomes at Discharge from FFT

*These outcomes are reported only for youth who were identified with this problem at enrollment. Note that the number of youth included in the measure of negative drug screens is very low (15 youth in each of the past two years) and therefore may not be representative of substance use outcomes for the program.
FFT Outcomes 6 Months Post-Discharge

The follow-up sample, which includes a total of 77 youth, may not be representative of all youth clinically discharged from FFT. The following limitations apply:

- Only a subset of providers currently collects follow-up data.
- Youth completing treatment are overrepresented in the follow-up sample (95% of the follow-up sample vs. 86% of youth clinically discharged in FY 2012/2013).
- The follow-up sample may be lower risk than the overall population of youth served by FFT in Pennsylvania (at enrollment, 27% of the follow-up sample was at immediate risk of placement vs. 42% of all clinical discharged youth).

**Chart 4: Outcomes 6-Months Post-Discharge from FFT**
Implementation Quality: FFT

Clinical supervisors rate therapist adherence to the FFT clinical model on a weekly basis, and then use these ratings to complete a Global Therapist Rating (GTR) for each FFT therapist at least three times per year. The GTR includes two indicators:

- **Dissemination Adherence**: The degree to which the therapist adheres to FFT protocols such as timeliness of documentation, appropriate spacing of sessions, flexible scheduling, and responsiveness to community partners.

- **Fidelity**: A reflection of therapist competence—e.g., sophistication of interventions, tailoring treatment to the family—and adherence—e.g., applying the model as intended and doing the “right thing at the right time.”

Cut-off scores indicate whether the therapist demonstrates satisfactory dissemination adherence and model fidelity.

<table>
<thead>
<tr>
<th></th>
<th>FY 2011/2012</th>
<th>FY 2012/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of therapists with at least one GTR</td>
<td>51</td>
<td>41</td>
</tr>
<tr>
<td>Dissemination Adherence in desired range</td>
<td>63%</td>
<td>56%</td>
</tr>
<tr>
<td>Fidelity in desired range</td>
<td>69%</td>
<td>81%</td>
</tr>
</tbody>
</table>

The combination of low DA scores with higher Fidelity scores indicates that therapists are struggling with administrative aspects of the program (e.g., timely documentation, assessment protocols), even while they are implementing FFT with clinical fidelity and competence.

The decrease in the number of therapists in FY 2012/2013 corresponded directly with a decrease in Dissemination Adherence (DA), suggesting that staff turnover resulted in the loss of staff able to effectively manage the administrative components of delivering FFT. At the site level, DA ranged from 0% to 100%. Of the nine FFT sites:

- Four had adequate levels of DA, with at least 75% of therapists rated in the desired range.
- Three small sites had one therapist each who did not rate within the desired range.
- Two sites had 40% or fewer therapists maintaining adequate DA, with reported issues related to timely documentation and chart management. In response, individual staff were put on improvement plans or, in some cases, let go.

Two situations may account for increased Fidelity across the state:
1) Four sites lost their FFT Site Supervisors and some experienced therapists in FY 2011/2012. As these sites trained new site supervisors and new hires gained more experience with the model, fidelity improved.
2) Sites let go therapists who were unable to maintain adequate fidelity.
## Multisystemic Therapy

### Overview of Youth Enrolled & Discharged

<table>
<thead>
<tr>
<th></th>
<th>FY 2011/2012</th>
<th>FY 2012/2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of teams reporting</td>
<td>45</td>
<td>45</td>
<td>0</td>
</tr>
<tr>
<td>Total youth served (new and previously enrolled cases)</td>
<td>2,201</td>
<td>2,045</td>
<td>-156</td>
</tr>
<tr>
<td><strong>Youth Enrolled</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New youth enrolled</td>
<td>1,610</td>
<td>1,529</td>
<td>-81</td>
</tr>
<tr>
<td>Percent of youth enrolled who were at imminent risk of being placed in a more restrictive setting</td>
<td>78%</td>
<td>77%</td>
<td>-1%</td>
</tr>
<tr>
<td><strong>Youth Discharged</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of youth discharged</td>
<td>1,676</td>
<td>1,544</td>
<td>-132</td>
</tr>
<tr>
<td>Administrative withdrawal</td>
<td>14%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>Clinical discharge</td>
<td>86%</td>
<td>86%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Average Length of Stay (in months)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For youth completing treatment</td>
<td>4.6</td>
<td>4.6</td>
<td>0.0</td>
</tr>
<tr>
<td>For youth not completing treatment</td>
<td>2.9</td>
<td>2.8</td>
<td>0.1</td>
</tr>
</tbody>
</table>

---

14 Data is included for 45 of 48 teams in FY 11/12 and 45 of 49 MST teams in FY 12/13. Three teams did not submit data in INSPIRE. A fourth team, which began providing MST in Nov. 2012, is not included because the team provides an adaptation of MST, MST for Problem Sexual Behavior (MST-PSB), and does not serve the traditional MST population.

15 Throughout this report, youth receiving MST for Problem Sexual Behavior (MST-PSB) are excluded from the data. MST-PSB outcomes are available upon request.

16 Total number of youth discharged is a sum of successfully, unsuccessfully, and administratively withdrawn youth.

17 The category of administrative withdrawals is intended to capture youth discharged prior to completing the program for non-clinical reasons that are outside of the program’s control (e.g., the family moving, loss of funding, or the youth being placed for an event that occurred prior to program enrollment).
Youth Demographics

Two charts below highlight demographic information for the 1,529 youth enrolled in MST in Fiscal Year 2012/2013. The average age of enrolled youth was 15.1 years.

Chart 1: Sex of Youth Enrolled in MST

- Male: 64%
- Female: 36%

Chart 2: Race/Ethnicity for Youth Enrolled in MST

- White: 64.9%
- Black/African-American: 20.3%
- Hispanic/Latino: 8.8%
- Multiracial: 5.4%
- Other Race or Ethnicity: 0.7%

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18 “Other Race or Ethnicity” includes Asian (0.2%), Pacific-Islander (0.0%), American-Indian (0.3%), and Other (0.2%).
Referral Sources

While the overall number of youth enrolled in MST decreased slightly from the previous fiscal year, the relative percentage of referrals from each source remained stable. The majority of referrals (80%) continued to come from county agencies (juvenile justice and child welfare). The largest change was the percent of referrals from the mental health system, which increased from 8% to 13%.

Chart 5: Referral Sources for Youth Enrolled in MST
MST Outcomes at Discharge

Chart 6: Youth Discharge Status, MST

*For MST, successful discharge is defined as completing MST and meeting the 3 Ultimate Outcomes identified by the model (living at home, in school, and no new offenses).

Chart 7: Treatment Outcomes at Discharge from MST

*These outcomes are reported only for youth who were identified with this problem at enrollment.
MST Outcomes 6 Months Post-Discharge

The follow-up sample, which includes a total of 177 youth, may not be representative of all youth clinically discharged from MST. The following limitations apply:

- Only a subset of providers currently collects 6-month follow-up data.
- Youth completing treatment are overrepresented in the follow-up sample (98% of the follow-up sample vs. 83% of youth clinically discharged in FY 2012/2013).

The percent of the follow-up sample at risk of placement when enrolled in MST is comparable to the risk level for youth discharged from the program (82% of the follow-up sample vs. 78% of clinical discharges in FY 2012/2013).

Chart 8: Outcomes 6-Months Post-Discharge from MST
Implementation Quality: MST

The MST model has a process of continuous quality improvement that makes use of several outcome indicators and measures of implementation quality. Here, two measures of implementation quality are evaluated.

- MST Experts conduct program implementation reviews for each team twice each year. These reviews evaluate outcomes, model fidelity, and adherence to required MST program practices, and culminate in a team plan to address areas needing improvement. We look here at the percent of teams meeting all 18 required program implementation practices.

- The Therapist Adherence Measure-Revised (TAM-R), which clients are asked to complete at regular intervals during MST, assesses the level of model adherent behavior that therapists demonstrate in session, from families’ perspectives. An average score of .70 is considered acceptable.

<table>
<thead>
<tr>
<th></th>
<th>FY 2011/2012</th>
<th>FY 2012/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teams meeting all 18 required program practices</td>
<td>31% (14 of 45)</td>
<td>34% (15 of 44)</td>
</tr>
<tr>
<td>Youth with TAM-R scores in the desired range</td>
<td>71%</td>
<td>70%</td>
</tr>
<tr>
<td>Average TAM-R score</td>
<td>.73</td>
<td>.72</td>
</tr>
</tbody>
</table>

Of 44 teams with program reviews completed in FY 2012/2013, 34% met all 18 required program practices. The primary areas of difficulty are the same as in the previous year:

- **Caseload (target not met in 25% of reviews):** MST requires therapists carry caseloads of 4 – 6 youth. Low referrals make it difficult for sites to meet this requirement. The number of teams not meeting this requirement has doubled since FY 2010/2011, when only 5 out of 46 teams (11%) did not have appropriate caseloads. This is discussed in greater depth in the section on Utilization.

- **Referrals to non-compatible programs (practice not met in 43% of reviews):** MST discourages youth receiving other services while enrolled in MST, because doing so is expected to result in poorer outcomes. In many communities, courts continue to mandate services such as group drug and alcohol counseling or center-based programs alongside MST. This has been a consistent challenge for providers over the past three years.

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19 In some instances, a joint program review is conducted for two or more teams from an agency. Therefore, the total number of reviews may be less than the total number of teams.
During FY 2012/2013, 70% of youth receiving MST had therapist adherence scores in the desired range. The percent of youth with TAM scores in the desired range has remained steady over the past 3 years but is below the MST Services target of 80%, indicating room for improvement. Each MST therapist has a professional development plan, which should take into account the therapist’s adherence scores and identify steps for improving adherence, if necessary. Over the past four years, average TAM-R scores have consistently exceeded the model target of .61.
Evidence-based Intervention Programs:
FY 2012/2013 Outcomes Summary

Multidimensional Treatment Foster Care

Overview of Youth Enrolled & Discharged

<table>
<thead>
<tr>
<th></th>
<th>FY 2011/2012</th>
<th>FY 2012/2013</th>
<th>Change</th>
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<tbody>
<tr>
<td>Number of sites reporting</td>
<td>4</td>
<td>5</td>
<td>+1</td>
</tr>
<tr>
<td>Total youth served (new and previously enrolled cases)</td>
<td>32</td>
<td>26</td>
<td>-6</td>
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**Youth Enrolled**

<table>
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<tr>
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<th>FY 2011/2012</th>
<th>FY 2012/2013</th>
<th>Change</th>
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<tbody>
<tr>
<td>New youth enrolled</td>
<td>22</td>
<td>19</td>
<td>-3</td>
</tr>
<tr>
<td>Percent of youth enrolled who were at imminent risk of being placed in a more restrictive setting</td>
<td>59%</td>
<td>88%</td>
<td>+29%</td>
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**Youth Discharged**

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<thead>
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<th>FY 2011/2012</th>
<th>FY 2012/2013</th>
<th>Change</th>
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<tbody>
<tr>
<td>Total number of youth discharged(^{20})</td>
<td>25</td>
<td>20</td>
<td>-5</td>
</tr>
<tr>
<td>Administrative withdrawal(^{21})</td>
<td>16%</td>
<td>10%</td>
<td>-6%</td>
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<tr>
<td>Clinical discharge</td>
<td>84%</td>
<td>90%</td>
<td>+6%</td>
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**Average Length of Stay (in months)**

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<th>FY 2011/2012</th>
<th>FY 2012/2013</th>
<th>Change</th>
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<tbody>
<tr>
<td>For youth completing treatment</td>
<td>7.2</td>
<td>6.9</td>
<td>-0.3</td>
</tr>
<tr>
<td>For youth not completing treatment</td>
<td>2.2</td>
<td>2.5</td>
<td>+0.3</td>
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</table>

Reasons for administrative discharge across the two years included court ordering the youth’s return home (although the youth had not yet completed treatment), detention by Juvenile Probation, and parents withdrawing youth from the program.

\(^{20}\) Total number of youth discharged is a sum of successfully, unsuccessfully, and administratively withdrawn youth.

\(^{21}\) The category of administrative withdrawals is intended to capture youth discharged prior to completing the program for non-clinical reasons that are outside of the program’s control (e.g., the family moving, loss of funding, or the youth being placed for an event that occurred prior to program enrollment).
Youth Demographics

Two charts below highlight demographic information for the 19 youth enrolled in MTFC in Fiscal Year 2012/2013. The average age of enrolled youth was 15.5 years.

Chart 1: Sex of Youth Enrolled in MTFC

![Pie chart showing sex of youth enrolled in MTFC]

- Male: 63%
- Female: 37%

Chart 2: Race/Ethnicity for Youth Enrolled in MTFC

![Pie chart showing race/ethnicity of youth enrolled in MTFC]

- White: 53.0%
- Black/African-American: 26.0%
- Multiracial: 21.0%

In the case of MTFC, data on ethnicity was obtained separate from data on race. Hispanic/Latino youth made up 21% of the youth enrolled.

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22 “Other Race or Ethnicity,” which totaled 0% for MTFC youth, includes Asian, Pacific-Islander, American-Indian, and Other.
Referral Sources

More than half of the youth enrolled in MTFC were referred by the child welfare system. Together, child welfare and juvenile justice made up 85% of the referrals for youth enrolled.

Chart 9: Referral Sources for Youth Enrolled in MTFC
MTFC Outcomes at Discharge

Chart 10: MTFC Youth Discharge Status

*For MTFC, successful discharge is defined as youth moving successfully through the Point & Level system, achieving treatment plan goals, and being discharged to a less restrictive placement.

The majority of unsuccessful discharges over the two year period were due to a youth needing a higher level of care (38%) and runaways (38%). In some cases, runaways resulted in removal by the referral source, even though the MTFC provider recommended continued treatment.

Chart 11: Youth Outcomes at Discharge from MTFC

*These outcomes are reported only for youth who were identified with this problem at enrollment. Drug screenings were not reported for any youth during FY 2011/2012 or FY 2012/2013.
MTFC Outcomes 6 Months Post-Discharge

Due to insufficient sample size, follow-up data for MTFC is not available at this time.

Implementation Quality: MTFC

To be eligible for certification, sites must first successfully discharge 7 youth and have an overall success rate of 66% or higher.

- Three of the five sites providing MTFC in FY 2012/2013 achieved MTFC certification. However, two of the certified sites are now closed due to chronically low enrollment.
- Two of the sites were not eligible for certification in FY 2012/2013, because they were new sites that had not yet achieved 7 successful discharges.

In general, sites must be operational for at least a year before applying for certification, but in Pennsylvania many sites have had to wait longer due to slow referrals.
Utilization Trends

Notable trends in the availability and utilization of evidence-based intervention program in Pennsylvania over the past several years are highlighted in the graphs on the following pages.

After periods of growth, the number of EBI teams for these three model programs leveled off, before decreasing over the past four years. At the same time, the number of youth enrolled annually has been decreasing over the past three years.

Over the past three years, many providers have reported significant underutilization of their EBI programs, which has in turn resulted in the closure of teams and/or smaller team size in an effort to narrow the gap between service capacity and service utilization.

From FY 2011/2012 to FY 2012/2013

- **FFT** enrollments decreased 5.7% statewide. However, this can be attributed to the 21% decrease in enrollments in southeast Pennsylvania, where FFT enrollments decreased by 21% across the three sites serving that region. Three sites experienced a 25% to 51% increase in enrollment from FY 2011/2012 to FY 2012/2013, while annual enrollment remained stable for two sites. The ninth site did not operate in FY 2011/2012.

- **MST** enrollments decreased 3.7% statewide. Of 12 providers for whom enrollment data was available across two fiscal years, six showed minimal change in enrollment rates (less than 5% change) and two increased enrollments by over 30%. The remaining four providers experienced a 10% to 47% decrease in enrollments from FY 2011/2012 to FY 2012/2013.

- **MTFC** enrollments decreased 13.6%. MTFC sites have been consistently underutilized, with utilization generally around 20-30% and rarely exceeding 50% for any one team. This has resulted in the closure of seven MTFC sites in the past 3 years.
Evidence-based Intervention Programs: FY 2012/2013 Outcomes Summary

Chart 14: Overall Number of Teams/Sites (new + sustained)

The chart above excludes teams that closed in a given year and is based on data available as of 9/20/2013.

Chart 15: Number of New Youth Enrolled In EBIs

The chart above excludes teams that closed in a given year and is based on data available as of 9/20/2013.
**Quarterly Trends for 2012/2013**

Over the past several months, utilization of EBIs has been the focus of sustainability efforts among EBI leaders in Pennsylvania (e.g., MST Services and Network Partners), as well as among individual providers. Efforts have focused on identifying and addressing – to the extent possible – barriers to referral and enrollment. Utilization data is presented differently for each model, based on data available and the manner in which utilization data is collected by the model. FFT and MST utilization data is drawn from the national data collection systems. Similar quarterly data is not readily available for MTFC.

**Functional Family Therapy**

![Chart 16: FFT Utilization Rates by Quarter, FY 2012/2013](image)

Chart 16 depicts quarterly utilization rates for FFT providers, using data on therapists’ target vs. actual caseload drawn from FFT’s Client Services System. Utilization is calculated as actual caseload / team capacity (i.e., target caseload).

A clear trend across the nine sites is not evident, and the chart highlights the significant instability in FFT use across the state with only two sites showing consistently high utilization. Sites can be divided into four categories:

- **Growth (blue solid lines):** These three sites showed growth during the year and were operating at or near full capacity in Q4. Two of these sites increased capacity as enrollments
also increased, showing consistently high utilization throughout the year. The other kept capacity steady while doubling the number of youth served from Q1 to Q4.

- **Capacity increased but utilization remained low** (green dashed lines): Two of the sites increased their capacity by 40% to 100% from Q1 to Q4. However, as large capacity was accompanied by only modest increases in enrollment, utilization remained relatively low.

- **Capacity decreased to match enrollments** (orange patterned lines): Three sites decreased capacity, which corresponded with an increased rate of utilization, suggesting they better matched program size to the rate of referrals. In one case, a 50% decrease in capacity from Q1 to Q4 corresponded with over 100% utilization in the final quarter.

- **Decreasing enrollment** (red dotted line): One site decreased capacity while also reporting a 48% decrease in the number of youth enrolled.

FFT utilization was also analyzed by looking at the number of teams with satisfactory utilization each quarter and those with utilization rates posing a significant threat to sustainability (Chart 17). A utilization rate of >84% was used as a cut-off for satisfactory utilization for the purposes of categorizing sites, although 85% utilization would still indicate unfilled openings in the program.

**Chart 17: FFT Utilization by Team, FY 2012/2013**

While the overall trend shown in Chart 17 is toward an increase in the number of teams with adequate utilization, the movement of sites through categories does not follow a predictable pattern (e.g., red to yellow to green). On average, sites saw a difference of 31% between their highest and lowest quarters’ utilization, with differences ranging from 14% to 58%
Charts 17 and 18 suggest that while a number of sites continue to have low utilization, there was positive movement at the end of the fiscal year. In Quarter 4, the number of sites being utilized at less than 85% decreased, the number of active cases increased, and there was a decrease in unused capacity relative to target caseload.
Multisystemic Therapy

Chart 19: Average Team Size and Caseload for MST, FY 2012/2013

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of youth discharged</td>
<td>380</td>
<td>381</td>
<td>383</td>
<td>426</td>
</tr>
<tr>
<td>Number of MST teams</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>43</td>
</tr>
</tbody>
</table>

Chart 19 depicts changes in average caseload per therapist and average MST team size across four quarters. The MST model requires that each MST team have 2 to 4 therapists. From a financial standpoint, teams of 4 are more easily sustained, assuming the team is well-utilized. Average caseload should be between 4 and 6 cases per therapist.

With the exception of Q2, the average caseload was below model requirements. (Further breakdown of caseload can be found in Chart 20.) Over the first three quarters, as the number of youth remained stable, team size and caseload had an inverse relationship. That is, as there are fewer therapists per team, therapist caseloads increase. This may reflect provider efforts to better match team size to actual utilization.

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21 In the Utilization section of the report, all MST data comes from the MST Enhanced Website. Three MST teams are excluded, because EPISCenter does not have access to their data in the MST EWS.
In Quarter 4, the number of youth discharged increased 10% over previous quarters, suggesting providers’ efforts to increase referrals and enrollments may have been started to bear fruit. Along with an increase in the number of youth, average caseload and team size both increased slightly.

**Chart 20: Average Therapist Caseloads for MST Teams, FY 2012/2013**

**Chart 21: MST Team Size by Quarter, FY 2012/2013**
The data in Charts 20 and 21 parallels that shown in Chart 19: While Quarter 2 saw fewer teams with low caseloads, there were more teams with 2 or fewer therapists which – as noted earlier – is difficult to sustain from a financial standpoint, because fewer youth served means a higher cost per youth to the provider. While Quarter 4 did see an increase in the number of youth discharged, more than half of the MST teams in Pennsylvania continued to have average caseloads of less than 4 youth per therapists, posing a serious threat to the future of those teams.
Sustainability Initiatives

Due in large part to the utilization concerns described above, many EBI providers report significant financial losses, which in turn pose a threat to sustainability. In November 2011, MST providers came together to outline their challenges in a letter and MST leaders within the state met with the Pennsylvania Commission on Crime and Delinquency (PCCD). This, in turn, prompted two initiatives directed at addressing the sustainability issues faced by providers.

First, a competitive funding announcement for “bridge” grants was issued by PCCD. This funding, intended to provide some financial relief while programs work to address barriers to sustainability, is tied to intensive technical assistance from the EPISCenter. Second, the EPISCenter began to collaborate more actively with providers and model disseminators (i.e., MST Services and FFT Inc.) to support strategic and well-planned sustainability efforts. This collaboration has been a fluid one, as described below.

Bridge Funding

Over the past decade, PCCD has made a significant financial investment in EBIs, which has resulted in better outcomes for the youth served as well as millions of dollars saved. In response to the financial concerns that threatened the sustainability of numerous EBI programs in the Commonwealth, PCCD created one-time Bridge Funding Grants. A funding announcement was released in the spring of 2013. With the support of their counties, which agreed to participate in any technical assistance provided as part of the grant, ten EBI providers applied for funding. Five programs were awarded grants, which began Oct. 1, 2013.

While funded programs are required to work with the EPISCenter to address sustainability challenges, the EPISCenter has offered support to all ten applicants. This “intensive technical assistance” began in Quarter 1 of FY 2013/2014 with a review of the funding application to identify the initial strengths and barriers described by the provider. EPISCenter staff then met with each site to further assess the areas of need and develop a written plan, outlining goals and action steps, to move the site toward sustainability. In many cases the next steps include outreach to county stakeholders for information gathering or collaborative problem-solving. The EPISCenter will be closely monitoring each program’s progress, with regular meetings and review of sustainability plans, revising plans as necessary.

Guiding Provider Sustainability Efforts

Following an MST provider meeting in October 2012, where providers discussed their shared barriers and next steps, the EPISCenter and MST Network Partner Adelphoi Village began organizing regular group conference calls with providers across the state to facilitate collaborative problem-solving and information sharing. These “Sustainability Workgroup”
meetings were soon expanded to include FFT and MTFC providers. Subcommittees were formed to focus on three priority areas identified by the group: outreach and advocacy, low utilization, and concerns stemming from regulatory audits. However, many providers were already devoting significant energy to local efforts to sustain their programs, and these statewide subcommittees consequently lacked the “human” resources needed to accomplish their goals.

In June 2013 the effort was restructured. Leaders from each EBI were identified\textsuperscript{24} and the Sustainability Workgroup was replaced with a Sustainability Leadership Committee, whose members could in turn work with individual sites to implement strategies that best fit their needs. While the Sustainability Leadership Committee has only met twice as a group, the EPISCenter meets regularly with the FFT and MST leaders to help guide and inform their strategies and facilitate information-sharing.

MST Services has a focus group dedicated to prioritizing the barriers experienced by Pennsylvania providers, identifying the factors driving those barriers, and developing targeted interventions which can be implemented under the supervision of each team’s MST Expert. This focus group includes key personnel from MST Services, as well as MST Network Partner Coaches working directly with MST teams in Pennsylvania. EPISCenter in turn works closely with MST Services and collaborates with the Coaches and Experts, providing valuable information about the state and local systems in which the programs operate. This structure and the EPISCenter-MST partnership have resulted in more dynamic and strategic support to providers by both organizations.

In November 2013, EPISCenter and MST Services initiated a series of four provider calls focused on common challenges identified at the MST Provider Meeting in October. During these monthly calls, providers take turns sharing the strategies they have used to overcome a specific obstacle, enabling providers to network and learn from one another. A similar series is under consideration for FFT.

Through these efforts, many providers have implemented more focused strategies to overcome barriers to utilization, addressing local factors to the extent possible. However, in some cases progress is limited by local or state practices. For instance, while an MST provider may consolidate its teams to reduce overhead and intensify outreach to stakeholders in an effort to increase referrals, lack of buy-in from certain county agencies or funding mechanisms that slow the enrollment process may continue to impact utilization of the service and the program’s bottom line.

\textsuperscript{24} This leadership included representatives from MST Services, the MST director from Network Partner Adelphoi Village, the Pennsylvania FFT site certification specialist, Pennsylvania’s FFT clinical supervisor from FFT Inc., and the MTFC Director from one MTFC agency.
Prior Recommendations & Current Progress

In December 2012, the EPISCenter released a report “Looking Back, Moving Forward: The History and Current State of Evidence-based Intervention in Pennsylvania.” After outlining the positive impact EBIs have had on the state, as well as the common challenges faced by providers, the report shared strategies for success and made a number of recommendations for addressing barriers.

Over the past year, many providers have implemented strategically-designed interventions aimed at targeting key barriers and improving sustainability. The EPISCenter has intensified its outreach to local stakeholders in an effort to increase awareness of ways that counties can benefit from and support sustainability, and PCCD awarded grants to a small number of EBI providers, offering some financial relief while providers develop plans to sustain their programs. At this time it is unclear to what extent recommendations regarding state-level action have been taken into consideration.

Below we share progress on the Next Steps and Recommendations identified in that report, as well as areas that remain in need. Appendix B outlines an updated set of recommendations.

<table>
<thead>
<tr>
<th>Next Step</th>
<th>Recommendations &amp; Relevant Agencies</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Take concrete and proactive steps to address the challenges faced by the programs, with the support and involvement of key stakeholders at the state level.</td>
<td>Create a best practice guide from the state, outlining policies and processes for effectively supporting EBIs and integrating information from multiple systems (e.g., child welfare, juvenile justice, mental health). - PCCD/JCJC, OCYF, OMHSAS, EPISCenter</td>
<td>None.</td>
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<tr>
<td></td>
<td>Discussion with other states to learn about their protocols and policies around EBIs, which could provide insight into new ways that Pennsylvania can effectively support EBI implementation and sustainability. - OCYF, OMHSAS, EPISCenter</td>
<td>The EPISCenter has communicated with Louisiana about Medicaid-funded implementation in that state, as well as participated in MST Medicaid Calls facilitated by MST Services, where information is shared by states and providers that fund MST using Medicaid. The OMHSAS Children’s Bureau is also in touch with representatives from other states. However, no concrete changes</td>
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<tr>
<td>Evidence-based Intervention Programs: FY 2012/2013 Outcomes Summary</td>
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<tr>
<td>Create avenues for continuing to educate a broad audience of county leaders about the benefits associated with EBIs and the role counties play in ensuring implementation is a success.</td>
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<td>2.</td>
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<tr>
<td>An “EBI Forum,” similar to the one held in 2010, to share best practices and educate counties regarding their critical role in supporting EBIs. - PCCD, OCYF, OMHSAS, EPISCenter</td>
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<tr>
<td>None.</td>
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<tr>
<td>Continued sharing of information through the EPISCenter newsletter for county leadership and BH-MCOs, which should focus on some of these key challenges and how counties can help. EPISCenter</td>
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<tr>
<td>A newsletter for local stakeholders is now distributed every 1-2 months. Topics address common sustainability challenges and the strategies for success. Resources such as forms or handouts are often created to accompany the newsletter.</td>
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<td>Targeted TA from a team of state partners to counties that continue to place high numbers of youth, yet are underutilizing existing EBIs. - PCCD, OCYF, EPISCenter</td>
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<tr>
<td>While this has not happened in the manner recommended, the EPISCenter has had several contacts with Philadelphia stakeholders. Through the TA process tied to the Bridge Funding Grants, EPISCenter is reaching out to some of the counties where utilization of existing services is low.</td>
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<td>Identify communities that are interested in adopting an EBI and counties where additional service capacity is needed, and provide technical assistance from the earliest stages of planning.</td>
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<td>3.</td>
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<td>A protocol for identifying communities in the early stages of planning would enable EPISCenter to provide this support on a larger scale. – OMHSAS, OCYF, EPISCenter</td>
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<tr>
<td>No progress has been made in developing a protocol. However:</td>
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<tr>
<td>• Through networking and outreach, as well as monitoring of BH-MCO newsletters, the EPISCenter makes an effort to learn of any counties where new EBIs are under consideration and reach out to offer assistance.</td>
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<tr>
<td>• The newsletter is used as a means of encouraging counties and BH-MCOs to contact the EPISCenter for support.</td>
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<tr>
<td>• Several planning and readiness resources were developed and posted on the EPISCenter website. A webpage specifically for counties and BH-MCOs was</td>
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| 4. | **Collect and disseminate more information about the long-term outcomes associated with EBIs in Pennsylvania.** | Discussion among state partners about this recommendation has not occurred. However, some progress has been made:
- The follow-up screens in INSPIRE and corresponding section of the INSPIRE Data Highlights Report were revised to facilitate more reliable and accurate reporting.
- The EPISCENTER conducted a survey of providers to determine the extent to which they currently collect follow-up data and the barriers to doing so.
- The EPISCENTER plans to include training around best practices for follow-up data collection at upcoming FFT and MST provider meetings. |

In 2013, EBI providers devoted significant resources to improving sustainability. While many have made progress toward financial stability and the Bridge Funding Grants will provide relief for some sites, Pennsylvania EBIs are not out of the woods yet. Continued monitoring and support is needed. Furthermore, there continue to be areas of the state with significant numbers of youth being placed but minimal use of EBIs.

The stability of EBIs could be greatly enhanced through policies and funding mechanisms that create an “EBI-friendly” environment. A forum for collaboration amongst state partners, which focuses specifically on EBIs, sets goals, identifies action steps to be taken by its members, and monitors progress, is needed.
Conclusion

Since the first FFT site was established in Pennsylvania in 1999, the Commonwealth has invested more than $35 million in evidence-based interventions\(^\text{25}\). EBIs across the Commonwealth have demonstrated high rates of treatment completion and positive outcomes for the majority of youth served, resulting in significant cost savings for Pennsylvania taxpayers. However, utilization of these Blueprint Model Programs has decreased over the past few years while costs have increased, posing a significant threat to the program sustainability and the availability of evidence-based programming for high risk adolescents in the state.

Two significant initiatives have attempted to address the challenges faced by EBI providers across the Commonwealth. First, PCCD awarded competitive “bridge” grants to five providers in October 2012. These grants, intended to provide some financial relief while programs work to address barriers to sustainability, is tied to intensive technical assistance from the EPISCenter. Second, the EPISCenter began to collaborate more actively with providers and model disseminators (i.e., MST Services and FFT Inc.) to support strategic and well-planned sustainability efforts. Many EBI providers have devoted extensive resources over the past year to making their programs more sustainable, and several of the recommendations made in the December 2012 report “Looking Back, Moving Forward” have been followed, with some positive results.

However, the future remains uncertain for these programs. The stability of EBIs could be greatly enhanced through policies and funding mechanisms that create an “EBI-friendly” environment. While several recommendations are outlined in Appendix B, such work would require strategic planning, a solution-focused approach, and dynamic collaboration across state agencies. A Continuous Quality Improvement model could provide a useful framework for such efforts.

\(^{25}\) This includes over $17 million in EBP grants awarded by PCCD from 1999-2008 for the start-up of FFT, MST, and MTFC, and over $18 million in Special Grant expenditures (funds given to counties by the Office of Children, Youth, and Families) from 2008-2013. PCCD Category 3 grant awards and Medical Assistance dollars are not included.
Reference