EPISCenter
EVIDENCE-BASED PREVENTION & INTERVENTION SUPPORT CENTER

Evidence-based Intervention Programs

FY 2011/2012 Outcomes Summary

Prepared for the Pennsylvania Commission on Crime and Delinquency

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PENNSTATE

Prevention Research Center
FOR THE PROMOTION OF HUMAN DEVELOPMENT

Executive Summary

The Evidence-based Prevention and Intervention Support Center (EPISCenter) is tasked with collecting quarterly Performance Measure data from all **Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST)**, and **Functional Family Therapy (FFT)** program providers funded through Special Grant funds from the Pennsylvania Department of Public Welfare's Office of Children Youth and Families (OCYF), grants from the Pennsylvania Commission on Crime and Delinquency (PCCD), or Medical Assistance (M.A.). The data collected and submitted to the EPISCenter represent the vast majority of teams providing service under these programs and includes all youth served regardless of funding source. The present report highlights data collected through the INSPIRE system during Fiscal Year 2011/2012 and includes data from Fiscal Year 2010/2011 for comparison.

- 2,684 new youth were enrolled in the evidence-based interventions (EBIs) during FY 2011/2012. At the same time, EBIs were underutilized compared to the existing service capacity in Pennsylvania.
- Across all three programs, the vast majority of referrals came from the child welfare and juvenile justice systems.
- Over 1,100 youth enrolled in an EBI during FY 2011/2012 were at imminent risk of placement at the time of enrollment, according to provider reports.

Among clinically discharged youth[1]:

- Using stringent and program-specific definitions of success, the majority of youth were discharged successfully (FFT-66%; MST-72%; MTFC-52%).
- At the point of discharge, rates of recidivism were low and the majority of youth remained in the community. Only 282 youth were placed at discharge.
- Follow-up data was limited but suggest that rates of recidivism and placement remain low 6-months post-discharge.

Data suggests significant costs savings associated with the use of these three EBIs in Pennsylvania:

- There is an estimated immediate cost savings of **$16.1 million** related to diversions from placement in FY 2011/2012.
- Based on all youth discharged in FY 2011/2012, the total economic benefit associated with crime reduction is estimated at **$71.4 million.**

[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 moving, loss of funding, or the youth being placed for an event that occurred prior to program enrollment).

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Introduction

The Evidence-based Prevention and Intervention Support Center (EPISCenter) is tasked with collecting quarterly Performance Measure data from all **Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST)**, and **Functional Family Therapy (FFT)** program providers funded through Special Grant funds from the Pennsylvania Department of Public Welfare's Office of Children Youth and Families (OCYF), grants from the Pennsylvania Commission on Crime and Delinquency (PCCD), or Medical Assistance (M.A.). The data collected and submitted to the EPISCenter represent the vast majority of teams providing service under these programs[2] and include all youth served regardless of funding source. The goal of quarterly and annual reports is to provide data on implementation quality and the impact of these evidence-based programs in Pennsylvania. This data is shared regularly with the Pennsylvania Resource Center for Evidence-Based Prevention and Intervention Programs and Practices.

The present report highlights data from Fiscal Year 2011/2012. Data from the previous fiscal year is included for comparison.

Data Sources

Readers should note that the launch of INSPIRE in the spring of 2011, on-going training of providers, and clarification of measurements has steadily increased the reliability and accuracy of data collected over the past year. FY 2011/2012 is the first fiscal year for which all data was available through INSPIRE. Data from FY 2010/2011 includes data collected with quarterly spreadsheets and a limited amount of data collected through INSPIRE (one quarter for FFT and MST; two quarters for MTFC).

Differences in the data from each fiscal year are evident on certain measures. Where the differences are small, they can likely be attributed to small but expected fluctuations in the data and improvements in the data collection process (i.e., utilizing client-level data rather than program-reported aggregate numbers).

Where the differences are more striking, possible explanations are provided. For instance, the percent of youth with negative drug screens decreased noticeably from FY 2010/2011 to FY 2011/2012 for both FFT and MST. One hypothesis for this change is that providers did not adhere to the definition of drug-free when aggregating and reporting data on spreadsheets in FY 2010/2011, whereas when using INSPIRE sites must actually enter the results of drug screens into the system in order for youth to be included in the calculations.

[2] See the Appendix for a table that lists all MTFC, MST, and FFT providers and the reporting periods for which they submitted data included in this report.

Further information about INSPIRE can be found in the Frequently Asked Questions at:
http://www.episcenter.psu.edu/sites/default/files/ebp/FAQ%20for%20INSPIRE%207-1-2012.pdf

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 (as reflected in the percent at risk for placement).
- 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. 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 Data

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

- At this time, limited information is available about the follow-up sample. It is unclear to what extent the data is representative of all youth discharged from the program. For instance, the discharge status (successful or unsuccessful) of youth for whom follow-up data is presented is not available.
- Many programs are not collecting follow-up data at this time. The data represents a limited subset of providers whose follow-up outcomes may not be representative of statewide outcomes.
- Follow-up data was not available for FY 2010/2011.

Functional Family Therapy

Functional Family Therapy (FFT) is an intensive, short-term family therapy model provided to youth who present with externalizing behaviors ranging from oppositional, defiant, and disruptive behaviors (i.e., at risk for delinquency) to serious, chronic criminal offenses. 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 provided over a period of about three 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.

In FY 2011/2012, there were 12 FFT sites operated by 10 providers in Pennsylvania. These sites offered FFT in 16 counties. Agencies providing FFT and the number of sites active in FY 2011/2012 were:

- Adams-Hanover Counseling Services (1 site)
- Cen-Clear Child Services (1 site)
- Children's Service Center (1 site)
- The Consortium (2 sites)
- Family Intervention Crisis Services (1 site)
- Family Services of NW PA (1 site)
- Intercultural Family Services (2 sites)
- Pinebrook (1 site)
- Valley Youth House (1 site)
- VisionQuest (1 site)

The Pinebrook FFT program was only operational during the first 2 weeks of FY 2011/2012 and Cen-Clear closed its program at the end of the second quarter.

Population Served: FFT

	FY 2010/2011	FY 2011/2012
Number of Providers Reporting	11	10
Youth Served		
New youth enrolled	1,248	1,052
New parents/caregivers served	1,625	882
Percent of youth enrolled who were at imminent risk of being placed in a more restrictive setting	10%	33%
Total youth served (new and previously enrolled cases)	1,494	1,417
Referral Sources		
Child Welfare	23%	16%
Juvenile Justice	51%	53%
Mental Health	3%	8%
Education	6%	4%
Other	17%	19%

There are two notable differences across the reporting periods:

- **Parents/caregivers served:** The difference is likely due to changes in the collection of this data over time. Providers used spreadsheets to report data in FY 2010/2011 and may have reported the total number of parents served rather than the number of newly served parents. Using INSPIRE, each caregiver is counted only once, at the onset of services. For the first half of FY 2011/2012, the number of caregivers was based on the number of caregivers completing the Family Self Report during the first month of treatment. Because some sites were not regularly administering the FSR, the number of new caregivers served was lower than expected. The decision was then made to have sites enter the number of parents served directly into INSPIRE. However, because two sites entered minimal data into the INSPIRE system, the number of caregivers continued to be underreported.
- **Percent of youth at risk of placement:** The increase from FY 2010/2011 to FY 2011/2012 may be due to providers being provided a clearer definition for "at imminent risk." In addition, as providers realized the importance of this variable to state reporting, they may have become more conscientious about identifying which youth were at risk.

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 indicators of **dissemination adherence** (the degree to which the therapist adheres to FFT protocols such as timeliness of documentation, appropriate spacing of sessions, flexible scheduling, responsiveness to community partners, etc.) and **fidelity** (reflecting 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.

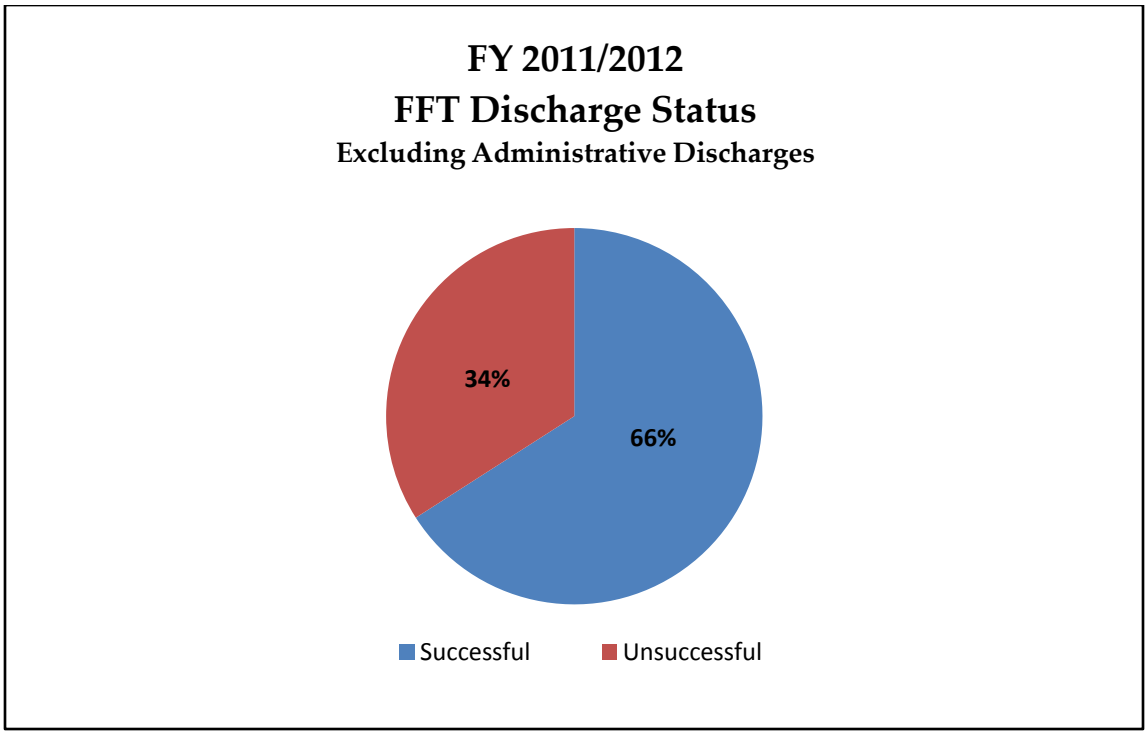
	FY 2010/2011	**FY 2011/2012**
Number of therapists with at least one GTR	38	51
Dissemination Adherence in desired range	66%	63%
Fidelity in desired range	87%	69%

A possible explanation for the decrease in fidelity ratings in FY 2011/2012 is that four sites lost their FFT Site Supervisors and some experienced therapists during the year. Consequently these sites moved from Phase 3 of implementation back to Phase 1. Fidelity can be expected to improve as these sites train new site supervisors and new hires gain more experience with the model.

Another possible explanation is that the dissemination of the Revised Supervisor Manual by FFT Inc. and training to improve the consistency and accuracy of ratings across sites resulted in more stringent ratings by FFT site supervisors and fewer therapists rated in the desired range.

Discharged Youth: FFT

	FY 2010/2011	FY 2011/2012
Total number of youth discharged[3]	1,125	1,102
Discharge Type		
Successful[4]	62%	57%
Unsuccessful	29%	30%
Administrative withdrawal[5]	9%	13%
Average Length of Stay (in months)		
For youth successfully discharged	4.0	3.8
For youth unsuccessfully discharged	2.8	3.0

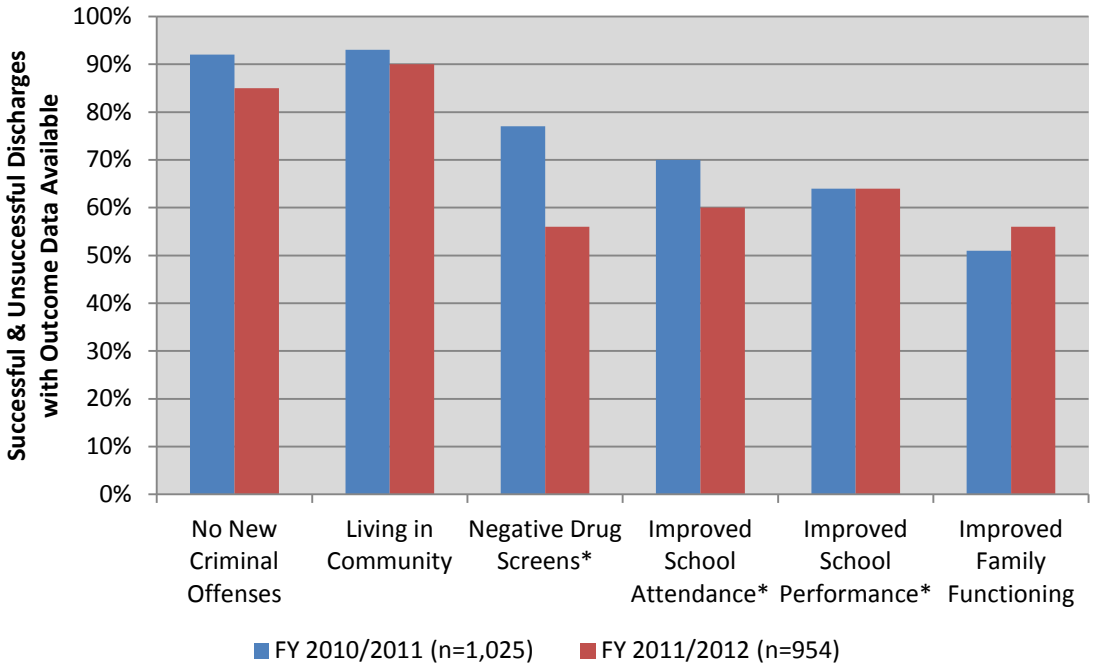


[3] Total number of youth discharged is a sum of successfully, unsuccessfully, and administratively withdrawn youth.

[4] For FFT, successful discharge is defined as completing the 3 phases of FFT and receiving average ratings of 3 or above on outcome measures completed by youth, family, and/or therapist. Therapist may override low ratings if there is clinical evidence of a positive outcome.

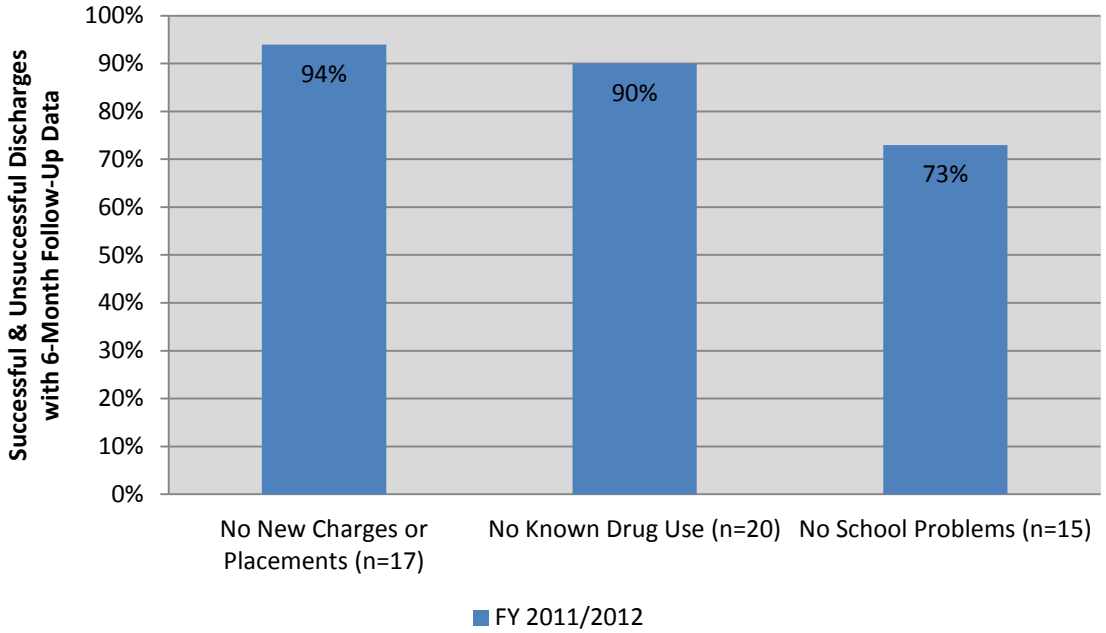
[5] The category of administrative withdrawals is intended to capture youth discharged prior to completing the program for non-clinical reasons that are outside of the program's control (e.g., the family moving, loss of funding, or the youth being placed for an event that occurred prior to program enrollment).

Outcomes at Discharge: FFT



*These outcomes are reported only for youth who were identified with this problem at enrollment.

Outcomes 6-Months Post-Discharge: FFT



Multisystemic Therapy

Multisystemic Therapy (MST) is provided to youth with significant externalizing behaviors, with the primary treatment population being delinquent youth and chronic or violent juvenile offenders. 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 child'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.

In FY 2011/2012, Pennsylvania had a total of 48 MST teams. Thirteen providers offered MST in 51 counties. Agencies offering MST and the number of teams active in FY 2011/2012 were:

- Adelphoi Village (11 teams)
- Beacon Light (2 teams)
- Child Guidance Resource Center (4 teams)
- Community Solutions Inc. (8 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)
- Mars Home for Youth (5 teams)
- Pennsylvania Counseling Services (3 teams)

Population Served: MST

	FY 2010/2011	FY 2011/2012
Number of Providers Reporting	13	12
Youth Served		
New youth enrolled	1,834	1,610
New parents/caregivers served	3,474	1,655
Percent of youth enrolled who were at imminent risk of being placed in a more restrictive setting	69%	78%
Total youth served (new and previously enrolled cases)	2,389	2,201
Referral Sources		
Child Welfare	44%	38%
Juvenile Justice	43%	46%
Mental Health	2%	8%
Education	4%	4%
Other	8%	4%

As it did for FFT, the number of parents/caregivers served by MST decreased from FY 2010/2011 to FY 2011/2012. The reasons for the decrease are probably similar. First, providers may have reported the total number of caregivers served each quarter, rather than the number of newly served caregivers. Second, with INSPIRE providers must enter caregiver information for each youth, and caregivers are only counted at the initiation of treatment; if caregiver information is not entered in INSPIRE, the caregiver will not be counted.

Implementation Quality: MST

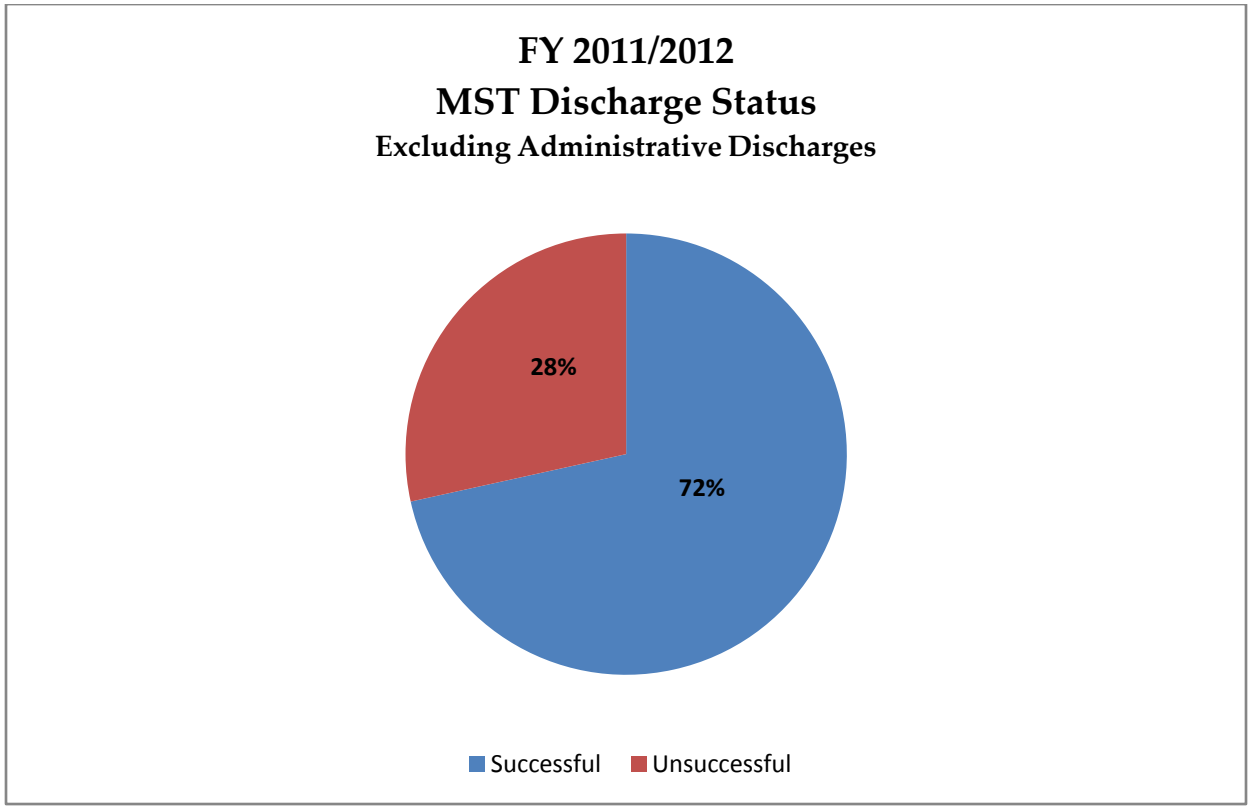
Twice a year, MST Experts conduct program implementation reviews for each team. These reviews evaluate outcomes, model fidelity, and adherence to required MST program practices, and culminate in a team plan to address areas needing improvement. **Of 25 program reviews entered into INSPIRE for FY 2011/2012, 40% met all 18 required program practices.** A closer look at the data using the MST Institute's Enhanced Web Site suggests two areas that many teams struggle with:

- **Caseload**: MST requires therapists carry caseloads of 4 – 6 youth. Low referrals make it difficult for sites to meet this requirement.
- **Referrals to non-compatible programs:** MST discourages placing youth in other services at the same time as 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.

Throughout MST, clients are asked to complete a Therapist Adherence Measure, assessing the level of model adherent behavior that therapists demonstrate in session, from families' perspectives. **During FY 2011/2012, 71.4% of youth receiving MST had therapist adherence scores in the desired range.** This percent is below the MST Services target of 80% of youth reporting adherence in the target range, indicating room for improvement. The percent with therapist adherence scores in the desired range in FY 2010/2011 was 72%, demonstrating consistency in the level of adherence over a 24-month period. 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.

Discharged Youth: MST

	FY 2010/2011	FY 2011/2012
Total number of youth discharged[6]	1,774	1,676
Discharge Type		
Successful[7]	71%	61%
Unsuccessful	20%	24%
Administrative withdrawal[8]	9%	14%
Average Length of Stay (in months)		
For youth successfully discharged	3.9	4.6
For youth unsuccessfully discharged	3.2	3.8

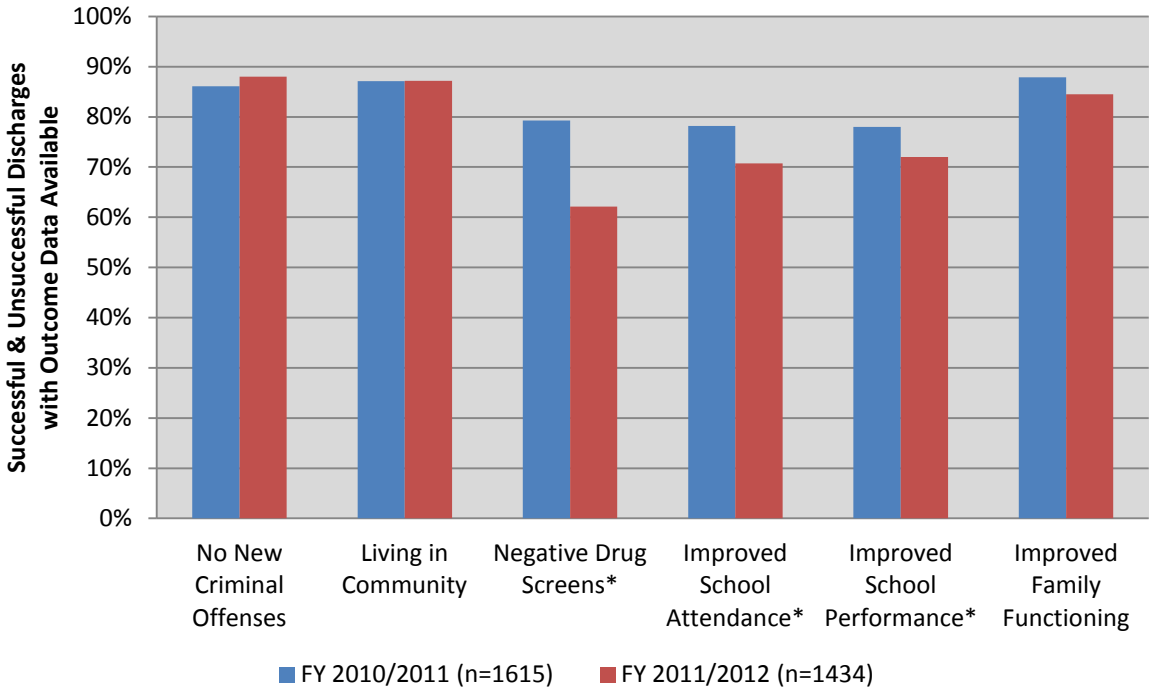


[6] Total number of youth discharged is a sum of successfully, unsuccessfully, and administratively withdrawn youth.

[7] 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).

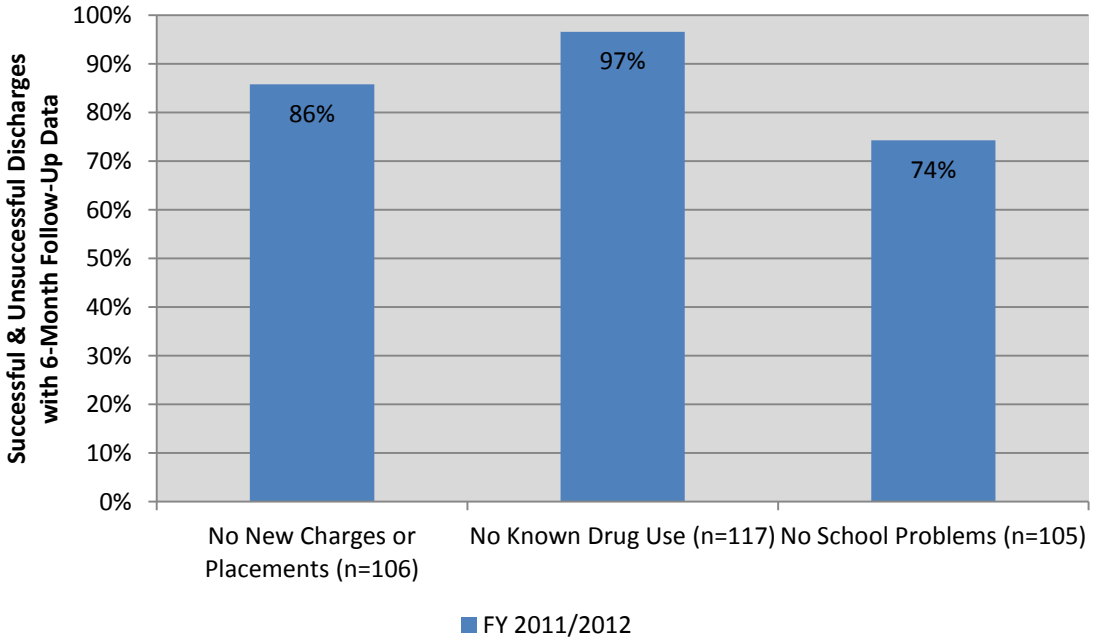
[8] The category of administrative withdrawals is intended to capture youth discharged prior to completing the program for non-clinical reasons that are outside of the program's control (e.g., the family moving, loss of funding, or the youth being placed for an event that occurred prior to program enrollment).

Outcomes at Discharge: MST



*These outcomes are reported only for youth who were identified with this problem at enrollment.

Outcomes 6-Months Post-Discharge: MST



Multidimensional Treatment Foster Care

Multidimensional Treatment Foster Care (MTFC) is a treatment alternative to group homes, residential care, and incarceration for youth who have problems with chronic disruptive behavior. 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.

In FY 2011/2012, Pennsylvania had 4 MTFC sites serving 9 counties. Agencies providing MTFC were:

- Children's Home of Reading (2 sites)
- Children's Home of York (1 site)
- Venango Children and Youth Services (1 site)

Population Served: MTFC

	FY 2010/2011	FY 2011/2012
Number of Sites Reporting	5	4
Youth Served		
New youth enrolled	57	22
New parents/caregivers served	52	31
Percent of youth enrolled who were at imminent risk of being placed in a more restrictive setting	87%	59%
Total youth served (new and previously enrolled cases)	71	32
Referral Sources		
Child Welfare	59%	53%
Juvenile Justice	38%	42%
Mental Health	3%	5%
Education	0%	0%
Other	0%	0%

The decrease in the number of youth enrolled in MTFC from FY 2010/2011 to FY 2011/2012 is significant, from 57 to 22 youth. This decrease cannot be attributed solely to the reduction in the number of MTFC sites and is evidence of the challenge MTFC sites face in maintaining adequate program census. For a 12-month period, four MTFC sites have a total capacity of approximately 80 youth. **Pennsylvania MTFC sites are operating at less than 25% of capacity.**

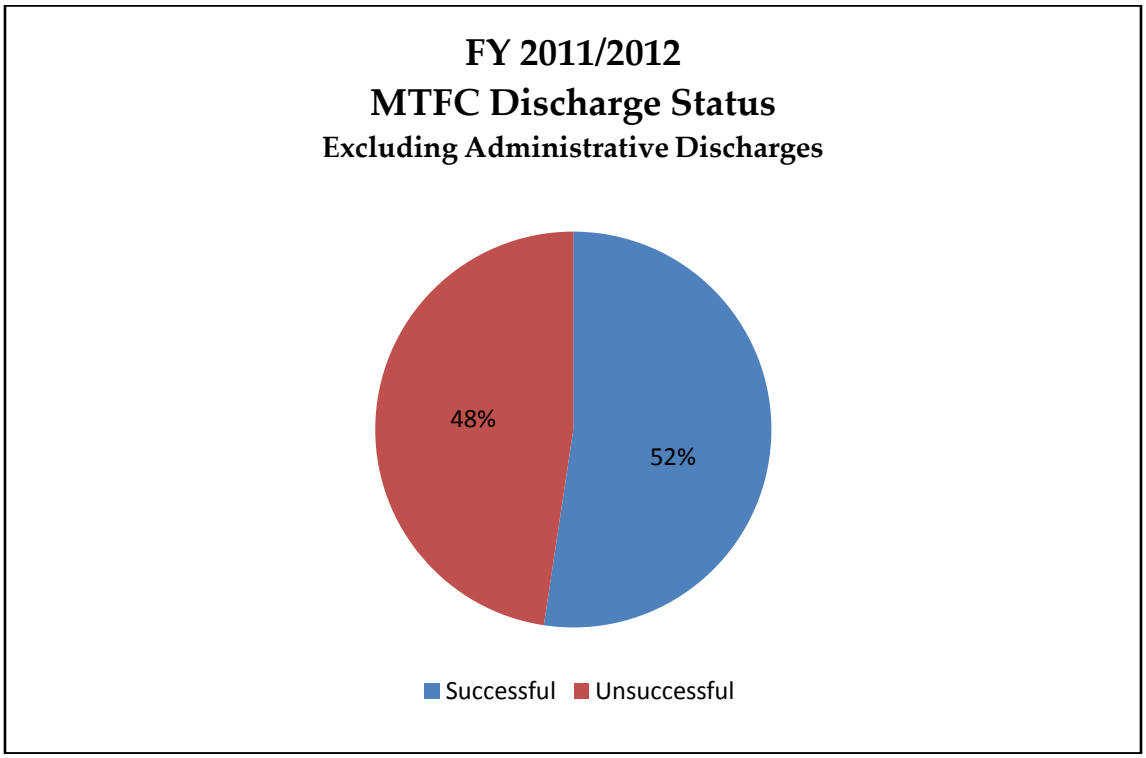
Implementation Quality: MTFC

During FY 2011/2012, two of four sites received program assessments or reviews from TFC Consultants, the organization responsible for the dissemination and oversight of MTFC implementation. Both sites met minimum program standards at review, indicating satisfactory model adherence.

Two sites, Children's Home of Reading in Lehigh Valley and Venango Children & Youth, have achieved MTFC certification. To be eligible for certification, sites must first successfully discharge 7 youth and have an overall success rate of 66% or higher. In Pennsylvania the slow rate of referrals has delayed the certification process for many sites.

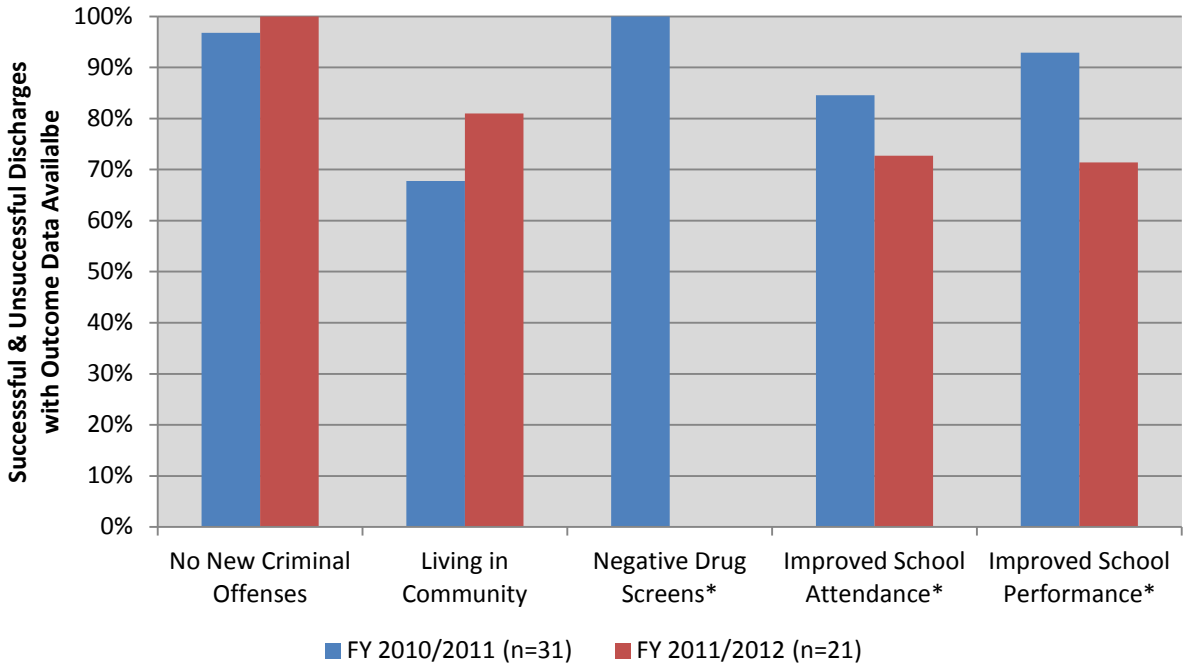
Discharged Youth: MTFC

	FY 2010/2011	FY 2011/2012
Total number of youth discharged[9]	33	25
Discharge Type		
Successful[10]	55%	44%
Unsuccessful	39%	40%
Administrative withdrawal[11]	6%	16%
Average Length of Stay (in months)		
For youth successfully discharged	8.2	7.3
For youth unsuccessfully discharged	3.3	3.1



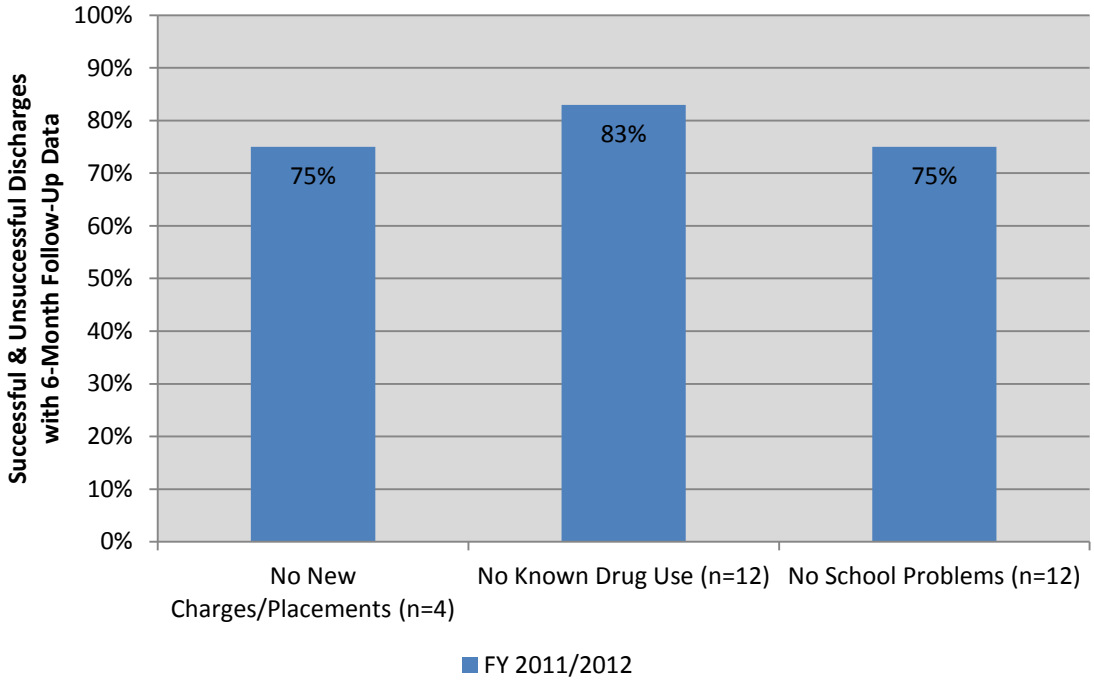
[9] Total number of youth discharged is a sum of successfully, unsuccessfully, and administratively withdrawn youth.
[10] For MTFC, successful discharge is defined as youth moving successfully through the Point & Level system, achieving treatment plan goals, and being discharged to a less restrictive placement.
[11] 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).

Outcomes at Discharge: MTFC



*These outcomes are reported only for youth who were identified with this problem at enrollment. Substance use outcomes were not reported for any youth during FY 2011/2012.

Outcomes 6-Months Post-Discharge: MTFC



Economic Benefits of Evidence-based Intervention

Savings from Placement Diversions

In addition to the positive youth and family outcomes associated with evidence-based intervention, there are also economic benefits. One potential area of cost savings is the immediate savings associated with fewer youth going into expensive out-of-home placements. As presented in this report, 2,427 youth were clinically discharged during FY 2011/2012. Based on therapist reports, 1,148 (47%) of those youth were at imminent risk of placement in a more restrictive setting at the point of being enrolled in FFT, MST, or MTFC.[12] **In all, 1,678 youth were successfully discharged and 749 were unsuccessfully discharged from their programs, 282 of whom were placed at discharge.**

If we assume that every youth discharged (successfully or unsuccessfully) went through the intervention program at full cost and that youth who were placed upon discharge went into a 90-day placement at full cost, and compare this to the cost of simply placing every youth who was at risk of placement and not serving youth who were not at risk, **there is an immediate cost savings of $16.1 million related to diversions from placement across the three programs.**[13]

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) compared to the actual average length of stay for MTFC (222 days), 2) the number of youth served being too low to "tip the balance" in favor of evidence-based placement, and 3) relatively new providers (less than 3 years) who are still learning the clinical model and will have more successful outcomes as they gain experience. 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.

[12] 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, 160 of 561 (28.5%) youth clinically discharged from FFT were at risk of placement at enrollment. Placement risk was missing for 393 youth and this percent – 28.5% - was used to estimate the number of those youth who were at risk.

[13] Estimated savings from placement diversion is based on data available at the time of this report. Estimated placement cost is based on the average YDC/YFC per diem and a 90 day length of stay. This estimate will be updated when data regarding the cost of private residential placements and the average length of placement are available.

	FFT	MST	MTFC	TOTAL
Potential Placement Costs[14]	$11,448,581	$36,317,127	$588,914	$48,354,622
Actual Program + Placement Costs[15]	$7,662,525	$23,227,577	$1,346,274	$32,236,377
Total Savings	**$3,786,056**	**$13,089,550**	**-$757,360**	**$16,118,246**

Further information about the impact of EBIs in Pennsylvania on placement rates can be found at: http://www.episcenter.psu.edu/sites/default/files/ebp/Placement%20Data%205-2012.pdf

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.).

In 2008, the Pennsylvania State Prevention Research Center published a report on the economic return on investment associated with the implementation of a number of evidence-based programs in Pennsylvania, including MTFC, MST, and FFT (Jones, Bumbarger, Greenberg, Greenwood, & Kyler, 2008). The estimated cost-benefit per youth from that report was translated into 2011 dollars using the Consumer Price Index. We then calculated the estimated economic benefit related to crime reduction associated with these programs for FY 2011/2012 (see Table below). **Based on all youth discharged from one of these programs in FY 2011/2012, the total economic benefit is estimated at $71.4 million.** 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.

[14] **Potential Placement Costs** = (Placement cost per youth x Youth discharged who were at risk at time of admission). Placement cost per youth is based on average per diem for a YDC/YFC placement in FY 2011/2012 (OCYF Bulletin 00-11-02). A conservative approach of 90 days was used.

[15] **Actual Costs** = (Program cost per youth x Youth discharged) + (Placement cost per youth x Youth placed). Program cost per youth is based on average across providers or sites for each program, using BH-MCO rates as reported by providers and average length of stay for successful cases in FY 2011/2012. For MTFC, program cost includes room and board.

Program	Benefit-Cost per Youth (2011$)	Youth Discharged FY 2011/2012	Estimated Economic Benefit (crime reduction)
FFT	$35,483	1,102	$39,102,266
MST	$18,135	1,676	$30,394,260
MTFC	$76,064	25	$1,901,600

Reference

Jones, D., Bumbarger, B. K., Greenberg, M. T., Greenwood, P., & Kyler, S. (2008). *The Economic Return on PCCD's Investment in Research-based Programs: A cost-benefit assessment of delinquency prevention in Pennsylvania.* University Park, PA: The Pennsylvania State University.

Please contact Liz Campbell, Ph.D., at ecampbell@episcenter.org
or (717) 233-1350 with questions about this report.

The EPISCenter is a project of the Prevention Research Center, College of Health and Human Development, The Pennsylvania State University, and is supported through funding from the Pennsylvania Commission on Crime and Delinquency and the Pennsylvania Department of Public Welfare. For more information:
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