

GENERAL INFORMATION

**Treatment
Description**

Acronym (abbreviation) for intervention: FCT

Average length/number of sessions: 6 months, avg. 50-70 face-to-face sessions

Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, transportation barriers): FCT provides a holistic approach with families in their homes. It emphasizes all areas of family functioning relevant to treatment needs, as based on families' identification of both their needs, and barriers to their functioning well as a family system. As a result, the affective involvement and responsiveness needs that are related to cultural experiences become part of the treatment process. For example; cultural expectations regarding expressions of closeness, touch, and affection are considered when suggesting practice activities (enactments) that are related to the *Area of Family Functioning* (AFF) of Affective Responsiveness.

Parenting and religious values and beliefs in the context of child development, including sexual behavior, are addressed within the scope of treatment. Services revolve around relevant goals related to family functioning, family preservation, child welfare, family permanency, and reunification.

Additionally, cultural expectations regarding roles, structure, and integration of family members into activities that are developmental are considered when making suggestions for change to address the AFF connected to Affective Involvement (belonginess).

Trauma type (primary): Complex (Neglect, Emotional, Physical and Sexual Abuse, Abandonment, Losses, Domestic Violence; Multiple Placements including adoption disruption, and communities exposed to violence.)

Trauma type (secondary): Medical

Additional descriptors (not included above): FCT is designed to find simple, practical, and common-sense solutions for families faced with the disruption or dissolution of their family. This disruption can be due to external and/or internal stressors, circumstances, or forced removal of their children from the home due to the youth's delinquent behavior or to parent's harmful behaviors. A foundational belief influencing the development of FCT is that the recipients of service are great people with tremendous internal strengths and resources. This core value is demonstrated via the use of individual family goals that are developed from strengths as opposed to deficits. Obtaining successful family engagement is a primary goal of FCT. FCT is provided to families of populations of all ages involved with agencies that specialize in child welfare, mental health, substance abuse, developmental disabilities, juvenile justice, and crossover youth. Critical components of FCT are derived from both Eco-Structural Family Therapy and Emotionally Focused Therapy, enhanced with additional components derived from direct practice experience with clients.

Effective delivery of FCT is contingent upon a three-part approach by management. All management levels must prioritize supporting effective treatment over business pragmatism. This includes assuring that funding is in place for the:

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<p>Treatment Description cont'd</p>	<ul style="list-style-type: none"> • Training to ensure that all direct FCT personnel (clinician, supervisor, and trainer) demonstrate theoretical knowledge and field skills competency. The FCT purveyor requires competency- based certification for both the clinician and the supervisor. • Fidelity measures built into the clinical process and the ensuing monitoring systems • Rigorous research and data collection systems
<p>Target Population</p>	<p>Age range: 0 to 100 all family members are involved</p> <p>Gender: <input type="checkbox"/> Males <input type="checkbox"/> Females <input checked="" type="checkbox"/> Both</p> <p>Ethnic/Racial Group (include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans): FCT is not geared or targeted to any one specific ethnic or racial group. Empirical studies of the model have demonstrated positive effects for numerous ethnic/racial groups. Most agency providers employ multi-lingual staff.</p> <p>Other cultural characteristics (e.g., SES, religion): FCT has been used with families from many different SES levels, including families from many cultures. These include recent immigrants from war-torn areas in the middle east, and second-generation clashes/conflict due to children/youth adapting and assimilating norms that conflict with those of their caregiver/parental system.</p> <p>Language(s): English and Spanish model components are available. Translation services have been obtained as specifically needed.</p> <p>Region (e.g., rural, urban): Empirical research results have demonstrated significant positive impacts in rural, urban, and mixed geographical areas.</p> <p>Other characteristics (not included above): The empirical study <i>Youth Outcomes Following Family Centered Treatment®</i>, as conducted in Maryland by Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2015), found significant positive outcomes for multiple groups. These include:</p> <ul style="list-style-type: none"> • African-American Adolescent/Young Adult Males. • School-age children and early adolescents • caregivers who experienced losses • family violence • severe and chronic neglect • physical and sexual abuse • repeated traumas • Children in, or at risk for, placement in foster family care, residential treatment, detention centers, and psychiatric hospitals, • Families involved with adoption or post adoption programs.

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<p>Essential Components</p>	<p>Theoretical basis: Family Systems, Structural Family Therapy, Attachment Theory, Emotionally-Focused Therapy, Eco-Structural Family Therapy, Real Life Heroes.</p> <p>Key components: Joining & Assessment Phase, Restructuring Phase, Valuing Change Phase, Generalization Phase, Family Trauma Treatment</p>
<p>Clinical & Anecdotal Evidence</p>	<p>Are you aware of any suggestion/evidence that this treatment may be harmful? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Uncertain</p> <p>Extent to which cultural issues have been described in writings about this intervention 4– Research has demonstrated positive outcomes across a range of ethnic/racial groups. Cultural competency, awareness, and training are requisites for certification as an FCT clinician.</p> <p>This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please include citation:</p> <ul style="list-style-type: none"> • The FCT Foundation has been preparing annual <i>FCT Family Satisfaction Survey Reports</i> since 2016. Available upon request. • Family Centered Treatment Annual Family Satisfaction Survey Outcomes Report (2016-2018) Charlotte, NC Family Centered Treatment Foundation, Inc. • The Mentor Network and formerly Institute for Family Centered Services have created family satisfaction survey reports since 2008. • Innovations Institute, University of Maryland Division of Child and Adolescent Psychiatry (2010-2013) <i>FAMILY CENTERED TREATMENT (FCT) Maryland Quarterly Utilization, Fidelity, and Outcomes Report</i>. Baltimore, MD. University of Maryland. <p>Has this intervention been presented at scientific meetings? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please include citation(s) from last five presentations:</p> <p>FCT has been presented at over 20 scientific, national and international conferences over the last five years. We have cited 7 in which scientific/research outcomes were a focus of presentation.</p> <ul style="list-style-type: none"> • William E. Painter Jr.; <i>Family Centered Treatment</i> ®: <i>an EBP model for in-home services with outstanding engagement rates with families of crossover youth</i>, Mental Health Association of the Eastern Shore, Chesapeake College and the Eastern Shore School Mental Health Coalition’s 8th Annual Conference, Easton MD, November 2018

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Clinical & Anecdotal Evidence continued

- Timothy Wood, Stephanie Glickman; Family Centered Treatment® Implementing for Sustainable Outcomes. Colorado Behavioral Healthcare Council 2018 Conference, Breckenridge CO, October 2018
- Timothy Wood; Family Centered Treatment® Implementing for Sustainable Outcomes. *Canadian Mental Health Association National Conference*, Toronto ON, September 2017
- Charlotte Lyn Bright; Adapting juvenile justice interventions to serve youth with trauma histories. *International Academy of Law and Mental Health's 35th International Congress on Law and Mental Health*, Prague Czech Republic, July 2017.
- Charlotte Lyn Bright, Jill Farrell, William E. Painter, Andrew M. Winters, Bethany Lee, & Sara Betsinger; Family Centered Treatment and Juvenile Justice Outcomes. *Society for Social Work and Research 2016 Annual Conference*, Washington D.C, January 2016.
- William E Painter Jr.; A Quasi-Experimental examination of Family Centered Treatment; Outcomes for a Juvenile Delinquent Population; *CMHS National GAINS CENTER, 2010 Conference*, Orlando Florida, March 2010.
- Melonie Sullivan, Lori Snyder Benneer, & William E. Painter; A Quasi-experimental Examination of Family Centered Treatment®: Outcomes for a Juvenile Delinquent Population, *The National Research Conference on Child and Family Program and Policy 2009*, Bridgewater MA, July 2009.

Are there any general writings which describe the components of the intervention or how to administer it? Yes No

If YES, please include citation:

Painter WE, Smith MM. (2004). *Wheels of Change—Family Centered Specialists Handbook and Training Manual*. Richmond, VA: Institute for Family Centered Services.

Wood TJ, (2014) *Family Centered Treatment® Design and Implementation Guide*. Revised 2018, Charlotte, NC: Family Centered Treatment Foundation Inc.

Painter WE, Smith LB, Jr., (2010) *The Definitive Report for Family Centered Treatment®*, Revised 2018, Denver, NC: Institute for Family Centered Services & Family Centered Treatment Foundation, Inc.

Jaycox, L. H., L. J. Hickman, D. Schultz, D. Barnes-Proby, C. M. Setodji, A. Kofner, R. Harris, J. D. Acosta, and T. Francois, *National Evaluation of Safe Start Promising Approaches: Assessing Program Outcomes*, Santa Monica, Calif.: RAND Corporation, TR-991-1-DOJ, 2011.

Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2015). *Youth Outcomes Following Family Centered Treatment® in Maryland*. Baltimore, MD: University of Maryland School of Social Work.

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<p>Clinical & Anecdotal Evidence continued</p>	<p>Bright, C. L., Farrell, J., Winters, A., Betsinger, S., Lee, B. R. (2018) Family Centered Treatment, Juvenile Justice, and the Grand Challenge of Smart Decarceration. <i>Research on Social Work Practice</i>, 28(5) 638-645 sagepub.com/journals DOI: 10.1177/1049731517730127 journals.sagepub.com/home/rsw</p> <p>Painter, WE. (2012) A Strategic Approach to Reunification for Juveniles with Placements Out-of-Home. <i>FOCUS Newsletter of the Foster Family-based Treatment Association</i>, 18 (2).</p> <p>Muniute-Cobb, E. (2010) Learning from evaluation by peer team: a case study of a family counselling organization. <i>INTERNATIONAL JOURNAL OF TRAINING AND DEVELOPMENT</i>. 14(2) 95–111, Alfred Version of Record online : DOI: 10.1111/j.1468-2419.2010.00344.x</p> <p>Hunter, John A., Gilbertson, Stephen A., Vedros, Dani & Morton, Michael (May 2004) Strengthening Community-Based Programming for Juvenile Sexual Offenders: Key Concepts and Paradigm Shifts;. <i>CHILD MALTREATMENT</i>, Vol. 9, No. 2, 177-189 DOI: 10.1177/1077559504264261©2004 Sage Publications</p> <p>Sullivan, John P Sullivan, Melonie B., and Hopkins, Edward (2006) Family Centered Treatment: A Unique Alternative, <i>Corrections Today</i>, 68(3).</p> <p>Has the intervention been replicated anywhere? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other countries? Family Centered Treatment is currently being administered in 12 states, by 20 distinct organizations. Presently there are over 60 separate sites covering various geographical areas across the country. FCT has not attempted to replicate outside of the US.</p> <p>Other clinical and/or anecdotal evidence (not included above): FCT has 18 years of outcome data tracking and reporting. Outcome reporting is available upon request.</p>	
<p>Research Evidence</p>	<p>Sample Size (N) and Breakdown <i>(by gender, ethnicity, other cultural factors)</i></p>	<p>Citation</p>
<p>Clinical Trials <i>(w/control groups)</i></p>	<p>1. FCT (N) Group 1246/Control (N) 1,441</p> <p>Female 21% Male 79% African American/Black 67% Caucasian/White 27% Hispanic/Latino 5% Other 1% Mean Age (SD) 16.6 (1.4) Urban 13% Suburban 53% Large Town/Rural 34%</p>	<p>1. Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2015). <i>Youth Outcomes Following Family Centered Treatment® in Maryland</i>. Baltimore, MD: University of Maryland School of Social Work.</p>

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Clinical Trials
(w/control groups)
cont'd

2. FCT (N) Group 447/ Control (N) 888

Average Age at First Offense 12.85
Mean Age at Intake 15.20
Male 75%
Female 25%
African American 59%
Caucasian 31%
Hispanic 8%

From Urban or Mixed Geographical Area 78%
First Offense was Serious Category 1 or 2 Crime 18%

3. FCT (N) Group 1246/ Control (N) 693

Male 79.1%
Female 20.9%
Age at first delinquency 13.1
Race

White 26.9%
Non-White 73.1%

Location

Urban 12.9%
Suburban 53%
Rural 31%

Prior Adjudication for violent offense

Yes 16.7%
No 83.3%

Prior Commitment Placement

Yes 12.4%
No 87.6%

4. FCT (N) Group 187/ Control (N) 187

Gender

Male FCT 49.2%
Female FCT 50.8%
Male Non FCT 50.2%
Female Non FCT 49.7%

Race

White-FCT 89.3%
White-Non FCT 86.6%
American Indian FCT 4.2%
American Indian Non FCT 0.0%
Black FCT 6.4%
Black Non FCT 13.3%

2. Sullivan, M. B., Bennear, L. S., Honess, K. F., Painter, W. E., & Wood, T. J. (2012). Family Centered Treatment—An alternative to residential placements for adjudicated youth: Outcomes and cost effectiveness. *OJJDP Journal of Juvenile Justice*, 2(1), 25-40.

3. Bright, C. L., Farrell, J., Winters, A. M., Betsinger, S., & Lee, B. R. (2018). Family Centered Treatment, juvenile justice, and the grand challenge of smart decarceration. *Research on Social Work Practice*, 28(5), 638-645. doi:10.1177/1049731517730127

4. The Indiana University Evaluation Team & The Department of Child Services.(2018) Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project Final Report. Indianapolis, IN: Indiana University School of Social Work and Indiana Department of Child Services.

Available at: https://www.in.gov/dcs/files/20180102_FinalReportfromdcsandIU.pdf

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<p>Clinical Trials (w/control groups) cont'd</p>	<p>Mean Age FCT 8.62 Non FCT 8.20 Number Focus Children FCT 3.14 Non FCT 3.19</p>	
<p>Randomized Controlled Trials</p>	<p>5. Technical Report Continuum Groups: Prevention/Promotion, Intervention/Treatment Age Range 5-21 BROWARD COUNTY SAFE START</p> <ul style="list-style-type: none"> • Intervention type: Family-Centered Treatment® (intensive, home-based, family-centered therapy) • Intervention length: Up to six months • Intervention setting: In-home • Target population: Children who were exposed to all types of violence, with a focus on exposure to domestic violence • Age range: 0–8 • Primary referral source: Henderson Mental Health Center (Family Resource Team), ChildNet, Women in Distress, Broward County Sheriff’s Office <p>The Broward County Safe Start Program implemented a family-centered, intervention intended to improve outcomes for children (ages 0-8) exposed to violence. The program included three phases: assessment and joining; individual and family counseling; and termination or generalization. A full description of the program can be found in National Evaluation of Safe Start Promising Approaches: Assessing Program Implementation (Schultz et al., 2010). The evaluation of this program consisted of a randomized controlled trial of their intervention, with randomization occurring at the family level, and a 6-month wait-list control group. A total of 201 families were recruited, but only 94 (47%) were retained at 6 months, and only 35 of these were in the control group.</p>	<p>5. Jaycox, L. H., L. J. Hickman, D. Schultz, D. Barnes-Proby, C. M. Setodji, A. Kofner, R. Harris, J. D. Acosta, and T. Francois (2011) <i>National Evaluation of Safe Start Promising Approaches: Assessing Program Outcomes</i>, Santa Monica, Calif.: RAND Corporation, TR-991-1-DOJ</p>

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<p>Randomized Controlled Trials cont'd</p>	<p>Participants in the study were largely minorities and impoverished, with about 30 percent of children scoring in the clinical range at baseline for PTSD symptoms and about one third of caregivers reporting parenting stress in the clinical range.</p>	
<p>Other Research Evidence</p>	<p>6. FCT (N) Group 452/ Group Care (N) 459 Following propensity score matching, study examined juvenile justice outcomes – re-adjudication and commitment, following discharge from treatment, in a sample of 911 youth. Matching Variables of the sample included age at admission, sex, race, location type (urban, suburban, rural/ large town, prior adjudication for violent offense, prior committed placements, #of prior delinquency complaints, age at first complaint, #of prior placement commitments and child welfare history.</p> <p>7. FCT Families >9,000</p> <ul style="list-style-type: none"> • Age range of youth 3-21 • Entrance Criteria: Social Welfare, Juvenile Justice (court involved), Mental Health Diagnosis, School, Managed Care, Other • Urban, Rural, Suburban, Mixed <p>8. The study is designed to understand the experiences and perceptions of service providers who provide Family Centered Treatment (FCT) to juvenile court-involved families. The study will explore the experiences about the level of comfort and skill in working with traumatized youth, the procedures they use to assess for trauma, the adaptations they make to existing services in the cause of trauma, and their perceptions of the success of these efforts. The purposes of the study are to assess service providers' level</p>	<p>6. Bright, C. L. (2017) Final Summary Report for “Building the Evidence Base: Family Centered Treatment for Crossover Youth”, Baltimore, MD: Funded by the Annie E. Casey Foundation, with matching funds supplied by the University of Maryland School of Social Work and Mentor.</p> <p>7. Annual Reports published by Institute for Family Centered Services 2008, 2009, 2010, 2011, 2012, and 2013. Annual Reports The MENTOR Network 2014 and 2015; Karen Honess and 2016 The MENTOR Network; Child and Family Services Center of Excellence: Painter.</p> <p>8. Bright, C. L. (2017, July). Adapting juvenile justice interventions to serve youth with trauma histories. Presented at the International Academy of Law and Mental Health’s 35th International Congress on Law and Mental Health, Prague, Czech Republic.</p>

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<p>Other Research Evidence cont'd</p>	<p>of comfort and skill in working with traumatized youth, the procedures they use to assess for trauma, the adaptations they make to existing services in the case of trauma, and their perceptions of the success of these efforts. As an exploratory, qualitative study, no specific hypotheses will be tested.</p>	
<p>Outcomes</p>	<p>What assessments or measures are used as part of the intervention or for research purposes, if any? The Family Assessment Device (FAD) and Child and Adolescent Needs and Strength (CANS) are used in select agencies for determination of areas of family functioning to address in treatment. Not currently evaluated for research purposes. In 2019, training and incorporation of an additional trauma assessment (ex'. UCLA PTSD Reaction Index or Family Assessment of Needs and Strengths (FANS) will be required for FCT sites. Adoption and implementation of the assessment(s) for assessment, treatment and research purposes.</p> <p>If research studies have been conducted, what were the outcomes?</p> <p>Study 1: <i>Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2015). Youth Outcomes Following Family Centered Treatment® in Maryland. Baltimore, MD: University of Maryland School of Social Work.</i></p> <p><u>Utilization</u></p> <ul style="list-style-type: none"> • The study includes a total of 1,246 youth who started FCT between fiscal years 2009 and 2013. • Most youth admitted to FCT during the study period were between the ages of 15 and 17 years old (75%), and the average age at admission just over 16 years old. The majority of youth were male and African American/Black. • Fidelity to the FCT practice model was high, with average fidelity to specified treatment activities exceeding 75% in fiscal years 2011-2013 (the years in which fidelity data was consistently captured in client records). Over 85% of the sample met FCT's definition of engaged in treatment (11 or more direct contacts). <p><u>Costs</u></p> <ul style="list-style-type: none"> • With shorter lengths of stay and a lower daily cost, the initial intervention cost for FCT was \$30,170 less per youth than group home placement for a statistically equivalent comparison group, on average. • Accounting for initial intervention costs and any additional residential placement costs during the first 12 months after the start of each intervention, FCT costs were an estimated \$41,729 less per youth, on average, for the FCT group as compared with the control group, who were placed in group homes. From 12 to 24 months post-admission, costs were \$20,339 lower on average for FCT youth. <p><u>Outcomes</u></p> <ul style="list-style-type: none"> • Relative to a statistically equivalent comparison group of youth who received group care, youth participating in FCT were significantly less likely to experience arrest resulting in conviction or sentences of incarceration in the criminal justice system. 	

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**Outcomes
cont'd**

- Among a matched subsample of youth ages 16 and over at initiation of treatment, FCT participants were significantly less likely to experience adult arrest leading to conviction or a sentence of incarceration than youth served in group care. Analysis of a matched female subsample showed non-significant differences between FCT participants and group care participants.
- Re-adjudication rates were relatively low and juvenile justice commitment rates were very low in both groups. No significant difference was found between youth receiving FCT and group care on readjudication or commitment in the juvenile justice system.

Study 2:

Sullivan, M. B., Benneer, L. S., Honess, K. F., Painter, W. E., & Wood, T. J. (2012). Family Centered Treatment—An alternative to residential placements for adjudicated youth: Outcomes and cost effectiveness. OJJDP Journal of Juvenile Justice, 2, 25–40.

Utilization

- The study includes a total of 447 youth who started FCT between years 2003 and 2007.
- The sample of youth in the comparison group (888) was drawn from the set of all youth discharged during the same timeframe from group homes, therapeutic group homes, and other residential placements offering similar types of services.
- For FCT youth the mean age at intake was 15.2 years with the average age of first offense being 12.85 years.
- The majority of youth were male (75%) with 59% identifying as African American, 31% Caucasian and 8% Hispanic.
- 78% of youth reported as living in urban or mixed. 12% reported rural.

Costs

- The average program cost for each youth in FCT was \$12,080. The average program cost for each youth was \$36,630 in Group Homes and \$36,348 in Therapeutic Group Homes—both more than three times the cost of FCT.
- Had FCT been unavailable, all youth would have been placed in Group or Therapeutic Group Homes, and the cost for serving those youth would have been \$16.3 million. Every \$1.00 spent on the FCT program saved the state of Maryland between \$2.03 and \$2.29
- The total estimated savings to the state was \$10.9 million to \$12.3 million over 4½ years.

Outcomes

- Although youth in both groups experienced declines in all four recidivism categories from pretreatment through year 1 posttreatment, there were no significant between-group differences. From year 1 through year 2 posttreatment, there was a greater decline in adjudications for youth in the FCT group, who had a lower proportion of adjudications than youth in the comparison group (p = .02).

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**Outcomes
cont'd**

Year 1 posttreatment findings for restrictive residential placements included the following:

- The proportion of youth in the FCT group with posttreatment placement was smaller than that of youth in the comparison group (38% vs. 50%; $p = .002$). This finding was associated with a small effect size (Cohen's $d = 0.24$).
- On average, the frequency of posttreatment placement was lower for youth in the FCT group relative to youth in the comparison group (0.50 vs. 0.63; $p = .03$). This finding was associated with a small effect size (Cohen's $d = 0.18$).
- On average, youth in the FCT group spent fewer days in residential placement than youth in the comparison group (64 vs. 91 days; $p = .002$). This finding was associated with a small effect size (Cohen's $d = 0.25$).
- There was no significant between-group difference regarding days spent in placement among youth who experienced placement.

Year 1 posttreatment findings for community detention placements included the following:

- Of the youth who were placed, those in the FCT group spent fewer days in placement than youth in the comparison group (45 vs. 54 days; $p = .007$). This finding was associated with a small effect size (Cohen's $d = 0.30$).
- There were no significant between-group differences regarding the proportion of youth with placement, frequency of placement, or average days spent in placement among all youth.

Year 1 posttreatment findings for pending placements included the following:

- Youth in the FCT group spent fewer days with pending placement than youth in the comparison group (14.6 vs. 24.3 days; $p = .01$). This finding was associated with a small effect size (Cohen's $d = 0.23$).
- Of the youth who were placed, those in the FCT group spent fewer days with pending placement than youth in the comparison group (51 vs. 72 days; $p = .004$). This finding was associated with a medium effect size (Cohen's $d = 0.41$).
- There were no significant between-group differences regarding the proportion of youth with placement or the frequency of placement.

Study 3:

Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2018) Family Centered Treatment, Juvenile Justice, and the Grand Challenge of Smart Decarceration. Research on Social Work Practice 1-8 ^a The Author(s) 2017 Reprints and permission: sagepub.com/journalsPermissions.nav DOI: [10.1177/1049731517730127](https://doi.org/10.1177/1049731517730127)
journals.sagepub.com/home/rsw

Responding to social work's grand challenge of smart decarceration, this study investigated whether Family Centered Treatment (FCT), a home-based service for juvenile court-involved youth, is more effective than group care (GC) in reducing recidivism. Outcomes are juvenile readjudication and commitment to placement, and adult conviction and sentence of incarceration.

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**Outcomes
cont'd**

Responding to social work's grand challenge of smart decarceration, this study investigated whether Family Centered Treatment (FCT), a home-based service for juvenile court-involved youth, is more effective than group care (GC) in reducing recidivism. Outcomes are juvenile readjudication and commitment to placement, and adult conviction and sentence of incarceration.

Method: Data were drawn from service provider and state administrative databases. Propensity score matching was used to create a sample of 1,246 FCT youth and 693 GC youth. Cox proportional hazard models estimated time to the four outcomes.

Results: FCT participants had a significantly lower risk of adult conviction and adult incarceration relative to youth who received GC. The findings for juvenile outcomes were nonsignificant.

Discussion: FCT shows more favorable adult criminal justice outcomes than GC, making it a potentially effective community-based service to support smart decarceration for juvenile court-involved youth. Juvenile services have an important role to play in the grand challenge of promoting smart decarceration. If social workers advocate reduced reliance on institutions to treat offenders, full-scale implementation of community-based alternatives to incarceration will be required. Further, as the juvenile justice system serves a greater proportion of its youth in the community, research on effectiveness of a broad array of services is necessary (Lipsey, 2012). The results of this study suggest that FCT is effective at reducing adult criminal justice involvement. These findings support the use of FCT as an alternative to GC for high-risk and/or high-need offenders. This research contributes to the literature on juvenile services and effectiveness and provides a basis for ongoing study of comprehensive, community-based treatment. This study is one piece of a comprehensive research agenda on social work's grand challenge of promoting smart decarceration.

Study 4:

The Indiana University Evaluation Team & The Department of Child Services.(2018) Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project Final Report. Indianapolis, IN: Indiana University School of Social Work and Indiana Department of Child Services.

Available at: <https://www.in.gov/dcs/files/20180102FinalReportfromdcsandIU.pdf>

Update: The Indiana University Evaluation Team & The Department of Child Services. (2019) Indiana IV-E Wavier Demonstration 2019 01 Semi-annual Report submitted to Administration for Children and Families. Indianapolis, IN: The Indiana University Evaluation Team & The Department of Child Services.

The effectiveness of the Family Centered Treatment (FCT) intervention was studied from January 1, 2015-December 31, 2015. All children referred for FCT received services as indicated via the model. Fidelity was established using a manualized training and certification of home based workers, supervision, consultation with national FCT Foundation clinicians, and monthly compliance checks on dosage of the intervention.

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**Outcomes
cont'd**

Children (and families) in the FCT treatment group were matched with children (and families) who received usual and customary care using propensity score matching. Matching characteristics were age, gender, race, region, county, number of focus children, involvement status, permanency goal, CANS score, and risk score. Overall, 20, 779 children were within DCS between January 1, 2015 and December 31, 2015 and 230 of those children not involved with the justice system received FCT. Matching characteristics were too restrictive and we were unable to obtain sufficient number of pairs to conduct and analysis. Therefore, region and permanency were removed as they were the characteristics restricting matching. The final data set then included 187 children who received FCT and 187 children who did not. The sample set demonstrated similar demographic characteristics with no significant differences.

Safety: Analysis of children remaining home throughout DCS involvement.

- Children who had received FCT were significantly more likely to remain in the home throughout services (55.61% vs. 39.04%, $p < .001$).
- Children in FCT had higher rates of repeat maltreatment during and 6 months post-DCS involvement. However, this was not statistically significant (10.61% vs. 5.98%).
- Children in FCT had a lower rate of repeat maltreatment 6 months after their involvement with DCS ended (1.68% vs. 4.35%). This was FCT favorable and not statistically significant.
- FCT children had higher rates of re-entry than non-FCT children into DCS following involvement, however this difference was not statistically significant (56.42% vs. 50%).

Permanency: Analysis of research questions associated with achieving permanency.

- Children who participated in FCT were more likely to have reunification as a goal than children who did not participate in FCT (99.07% vs. 95.83%). This was FCT favorable and not statistically significant.
- Children who did not participate in FCT had a higher rate of being a child in need of services (CHINS) than children who were in FCT (75.40% vs. 69.52%). This was FCT favorable and not statistically significant.
- Children in FCT had fewer days involved with DCS on average than children who did not have FCT (331 vs. 344). This was FCT favorable and not statistically significant.
- Children in FCT did have statistically significantly fewer days on average until reunification than non-FCT children (341 vs. 417, $p < .05$).

Well-being: To answer the research questions associated with well-being, the risk level associated with children who participated in FCT and those that did not was analyzed.

- Children who participated in FCT had a lower rate of being classified as “very high risk” as compared to children who did not (50.8% vs. 51.87%). This was FCT favorable and not statistically significant.

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**Outcomes
cont'd**

- Children who participated in FCT had a higher rate of being classified as “low risk” (1.6% vs. 0.53%). This was FCT favorable and not statistically significant.
- Child Abuse and Neglect Scores (CANS) analysis found that FCT youths’ family functioning climbed at a statistically significantly higher rate than Non-FCT youth over time, whereas Non-FCT youths’ scores climbed at a slower rate. Thus, FCT appears to be more effective in increasing the overall family functioning over time for youth ($p < .05$).

To clarify the well-being assessment, changes in child’s safety ratings were assessed.

- Children who had FCT had a statistically significantly higher rate of being rated as safe (35.71% vs. 28.49%, $p < .001$).
- Children who had FCT had a statistically significantly higher rate of being rated as conditionally safe than children who did not participate in FCT (39.56% vs. 27.93%, $p < .001$).
- Children who had FCT had a significantly lower rate of being rated as unsafe than children who did not participate in FCT (24.73% vs. 43.58%, $p < .001$).

Cost: The study analyzed total case cost and cost per child for each group. The average total cost of the case was statistically significantly higher for children in FCT (\$19,673 vs. \$17,719, $p < .05$). However, the cost per child was not statistically significant (\$10,277 vs. \$6,481) between groups. This finding is not surprising since the initial FCT startup imposed an additional cost to the DCS system. Startup costs for comparison group services were not included in the cost calculations.

Summary of FCT Comparison Findings: Overall, children and families who participated in FCT appear to fare better than children who do not participate in FCT. While the cost of administering the program is higher for children who participate in FCT than those who do not, children who participated in FCT have better outcomes associated with their safety, permanency goals, and well-being. Children who participated in FCT were more likely to remain in-home during their involvement with DCS, as well as be reunited with their family in shorter timeframe and more likely to be ranked as conditionally safe and safe.

From January 2015 – December 2017 the IU project team analyzed trends in family functioning scores using the Child Adolescent Needs and Strength (CANS) assessment for both Non-FCT youth and FCT youth. FCT youth started with a significantly lower family functioning than Non-FCT youth. It took nearly two years for FCT youths’ family functioning scores to catch up to Non-FCT youth. This suggests that FCT youth begin with a higher risk than Non-FCT youth.

However, FCT youths’ family functioning climbed at a statistically significantly higher rate than Non-FCT youth over time, whereas Non-FCT youths’ scores climbed at a slower rate. FCT appears to be more effective in increasing the overall family functioning over time for youth.

GENERAL INFORMATION

<p>Implementation Requirements & Readiness</p>	<p>Space, materials or equipment requirements?</p> <p>Assessed during a prospective organizations FCT Readiness Assessment, organizations should have the following available at launch of the model:</p> <ul style="list-style-type: none"> • Policies enabling the training requirements for FCT • Video review capacity for sessions. • Electronic Health Record capable of collecting and exporting adherence and outcome measures. • Employee/Trainee access to online training platform <p>Supervision requirements (e.g., review of taped sessions)? Supervisors of FCT must go through a Supervisor Certification process. The process entails online training with video & competency vetting by FCTF consultants, online testing to ensure proficiency, videotape submission of live supervisions with FCT clinicians performing case staffing, demonstration of proficiency within the video tape submissions. Additionally, supervisor trainees participate in supervisor-groups to affect collective learning, as well as an end-of-training proficiency review with a Certified FCT Master Trainer. FCT Supervisor Certification must be renewed biennially through continuing education.</p> <p>Upon request to become a Family Centered Treatment provider, organizations can seek licensure to implement through the Family Centered Treatment Foundation, Inc. (FCTF). FCTF is based in Charlotte, NC with the Administrative Office in Great Falls, VA. An initial Readiness Assessment is performed for each organization to determine feasibility, practicality, and sustainability of the model. Upon review of the RA, the FCTF Board of Directors determines if FCT licensure can be approved for the prospective organization. The FCTF is the principle overseer of implementation for all licensing components including training, supervision proficiency, fidelity adherence, and outcome monitoring.</p>
<p>Training Materials & Requirements</p>	<p>List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.</p> <ul style="list-style-type: none"> • Painter WE, Smith MM. (2004). <i>Wheels of Change—Family Centered Specialists Handbook and Training Manual</i>. Richmond, VA: Institute for Family Centered Services. • Wood TJ, (2014) <i>Family Centered Treatment® Design and Implementation Guide</i>. Revised 2018, Charlotte, NC: Family Centered Treatment Foundation Inc. • http://www.cebc4cw.org/program/family-centered-treatment/ Manuals and other relevant training material can be requested through the FCT Foundation. <p>How/where is training obtained?</p> <p>Training and certification is provided to organizations through licensing by the FCT Foundation. Training is performed online and on site at the licensed provider location.</p>

GENERAL INFORMATION

Training Materials & Requirements cont'd

What is the cost of training?

Costs for licensing, training (consultation), and oversight vary by site and is dependent based on scope of work and as determined during the organizational Readiness Assessment. Monthly costs are ongoing for the duration of licensure. Each licensed FCT organization is required to utilize a FCT consultant provided by the FCT Foundation. Consultation time/cost is expected to decrease over time as organizations become self-sufficient in their implementation of the FCT model. Onsite and Offsite consultation rates vary and are estimated in advance of service based on size and scope of the implementation project. FCT Foundation Board-approved fixed costs (2018-2019) for FCT include:

- Licensing per site. \$400/month
- 24/7 online training access per organization: \$200/month
- Fidelity/Adherence Monitoring and Oversight: \$30 per FCT personnel/month
- Offsite consultation (monthly): \$100/hour
- Onsite consultation (monthly): \$500/day
- Onsite consultation travel (set by gsa.gov rate)

Are intervention materials (*handouts*) available in other languages?

Yes No

If YES, what languages? Spanish

Other training materials &/or requirements (*not included above*):

Specialty training courses and recertification trainings are available on topics of trauma treatment, domestic violence, enabling successful reunification, court preparation, leadership and management, and treatment during holidays for FCT certified staff, utilization review, attachment needs/disorders, stakeholder alliance, foundations of FCT practice.

Pros & Cons/ Qualitative Impressions

What are the pros of this intervention over others for this specific group (*e.g., addresses stigma re. treatment, addresses transportation barriers*)?

As a family therapy model, FCT looks to address more than primary/presenting symptoms or behaviors exhibited. Instead, FCT addresses underlying repetitive behavioral interactions of the family system and does so by diagnosing and treating specific Areas of Family Functioning. Areas of Family Functioning (Epstein, Bishop, Ryan, Miller, & Keitner, 1993) provide the framework for Restructuring (phase 2 of FCT). Practice activities or enactments are linked to the area of functioning of concern. For instance, if 'Family Roles' was determined to be the area of most concern, then practice activities and /or changes designed to enable physical and emotional safety would be necessary. Likewise, FCT is distinctly able to assess and treat reoccurring (sometimes generationally) traumatic systemic events impeding the family from achieving optimal functioning. When there are identified multiple individual members of the family that are referred or are identified as in need of trauma treatment, all members of the family benefit from the referral of one member.

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<p>Pros & Cons/ Qualitative Impressions cont'd</p>	<p>What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)?</p> <p>Families who would benefit from receiving FCT must obtain services through a licensed FCT provider and are subject to the geographical catchment areas to which the licensed organizations operate. Duration of treatment is individualized based upon family need and complexity of the family functioning change process but historically has averaged six (6) months.</p> <p>Other qualitative impressions: In that FCT is a family systems treatment approach, each family member learns and develop methods and responses to support each other in their trauma triggers and sensory based responses (Painter, W., Wood, T., 2018) which in the long term becomes more sustainable and practical than seeking therapy for reoccurrence of symptoms.</p>
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