Family Centered Treatment (FCT)

Family Centered Treatment (FCT) is a family preservation program for juvenile offenders and their families. The program provides intensive in-home services as a cost-effective alternative to out-of-home placement and attempts to reduce the recidivism of participating youth, improve family relationships, and avoid jeopardizing community safety. FCT uses a strengths-based model that incorporates components of ecostructural family therapy and emotionally focused therapy and engages youth and their families through commitment to treatment and collaboration.

Treatment is provided by a trained therapist in the family's home or in other settings (e.g., school, workplace, home of a relative, community settings), with several hours of contact in multiple sessions each week, for an average of 6 months. Structured progress through FCT follows a four-phase model:

- In the joining and assessment phase, the therapist connects with the youth and family members to gain their acceptance and trust and challenges their modes of family functioning. The therapist works with the family to create a relationship through treatment, identifying family strengths and assessing family functioning. Assessments include the Family Centered Evaluation process (developed for FCT), any State- or contract-specific assessments, and the standardized Family Assessment Device.
- In the restructuring phase, the therapist addresses the origins of the behavior of youth and families and helps them to recognize and address their underlying emotional and attachment needs.
- In the valuing changes phase, the family members identify the changes they made that are of value to them and that they want to continue after FCT ends.
- In the generalization phase, family members demonstrate change independently and show they are able to handle difficult situations on their own and possess the tools and skills to function more effectively as a family system. Giving to others or to the community is integral to this phase.

Transitional indicators are used to ensure the family's successful completion of each phase, and progress is guided and documented by the therapist. In addition, trauma treatment is integrated throughout all phases of FCT, at any juncture during which it is indicated.

Before providing FCT, therapists must become certified via a competency training course, and recertification is required every 2 years. In addition, implementing agencies must become licensed, which involves providing the management, training, supervision, and data collection infrastructure to support the delivery of FCT. Maintenance of the FCT agency license requires monitored demonstration of fidelity to the four phases of the model.

Descriptive Information

Areas of Interest	Mental health promotion Substance abuse prevention
Outcomes	**Review Date: October 2013** 1: Recidivism 2: Posttreatment placement 3: Cost-effectiveness
Outcome Categories	Cost Crime/delinquency
Ages	13-17 (Adolescent)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White
Settings	Home

	Other community settings
Geographic Locations	Urban Suburban Rural and/or frontier
Implementation History	FCT has been provided since 2004 (when the training manual and model were formalized) by the Institute for Family Centered Services (IFCS), the development agency and flagship provider. IFCS is providing FCT in Florida, Indiana, Maryland, Massachusetts, North Carolina, and Ohio. In 2009, rights for and ownership of Family Centered Treatment were given to the Family Centered Treatment Foundation (formerly known as FamiliFirst), and since that time, additional agencies have been licensed to provide FCT in Indiana and Virginia.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: No Evaluated in comparative effectiveness research studies: Yes
Adaptations	Forms and tools have been translated into Spanish.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Indicated

Quality of Research

Review Date: October 2013

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Honess, K. F., Sullivan, M. B., & Painter, W. E., Jr. (2013). Cost effectiveness addendum to: Family Centered Treatment--An alternative to residential placements for adjudicated youth: Outcomes and cost effectiveness. Unpublished manuscript.

Sullivan, M. B., Bennear, L. S., Honess, K. F., Painter, W. E., Jr., & 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.

Supplementary Materials

Painter, B. (n.d.). A quasi-experimental examination of Family Centered Treatment: Outcomes for a juvenile delinquent population report addendum. Family Centered Treatment adherence measures. Unpublished manuscript.

Outcomes

Outcome 1: Recidivism	
Description of Measures	Recidivism was assessed using data obtained from the Maryland Department of Juvenile Services for four categories: frequency of offenses (charges of violation of the law), proportion of youth committing offenses, frequency of adjudications (court decisions to adjudicate the youth on the offense charges), and proportion of youth with adjudications. Data were obtained for participants' pretreatment status, the first 365 days following discharge from FCT or residential treatment (year 1 posttreatment), and days 366-730 following discharge from FCT or residential treatment (year 2 posttreatment).
Key Findings	In a retrospective study, adjudicated youth in Maryland who were eligible for both FCT (intervention group) and placement in residential treatment (comparison group) were assigned to one treatment group by the courts. The sample of youth in the FCT group was drawn from all youth discharged from FCT during the first 4.5 years of FCT field implementation in Maryland (July 2003 to December 2007), and the sample of youth in the comparison group was drawn from all youth discharged during the same timeframe from group homes, therapeutic group homes, and other residential placements offering similar types of services. 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). This finding was associated with a large effect size (Cohen's d = 4.3).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.2 (0.0-4.0 scale)

Outcome 2: Posttreatment placement	
Description of Measures	Posttreatment placement was assessed using data obtained from the Maryland Department of Juvenile Services for four types of placement: • Restrictive residential, which includes group homes, therapeutic group homes, therapeutic foster care, residential treatment centers, impact programs, wilderness programs, substance abuse programs, and secure confinements • Community detention, which refers to youth who remain in the home with supervision from the Department of Juvenile Services • Secure detention, which includes detention centers and reformatory placements • Pending, which refers to the waiting period between commitment to placement and available space For each placement type, four categories were examined: proportion of youth with placement, frequency of placement averaged over all youth, days spent in placement averaged over all youth (i.e., placement duration), and days spent in placement only among those youth who experienced placement (i.e., conditional duration). Data were obtained for the first 365 days following discharge from FCT or residential treatment (year 1 posttreatment) and days 366-730 following discharge from FCT or residential treatment (year 2 posttreatment).
Key Findings	In a retrospective study, adjudicated youth in Maryland who were eligible for both FCT (intervention group) and placement in residential treatment (comparison group) were assigned to one treatment group by the courts. The sample of youth in the FCT group was drawn from all youth discharged from FCT during the first 4.5 years of FCT field implementation in Maryland (July 2003 to December 2007), and the sample of youth in the comparison group was drawn from all youth discharged during the same timeframe from group homes, therapeutic group homes, and other residential placements offering similar types of services. 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. There were no significant between-group differences for secure detention placements at year 1 posttreatment. In addition, there were no significant between-group differences for any of the four types of placement at year 2 posttreatment.
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.2 (0.0-4.0 scale)

Outcome 3: Cost-effectiveness	
Description of Measures	Cost-effectiveness was assessed using data obtained from the Maryland Department of Juvenile Services and the FCT service provider, the Institute for Family Centered Services, for the average daily program costs in 2006 for each youth who received FCT and for each youth who received residential treatment.
Key Findings	In a retrospective study, adjudicated youth in Maryland who were eligible for both FCT (intervention group) and placement in residential treatment (comparison group) were assigned to one treatment group by the courts. The sample of youth in the FCT group was drawn from all youth discharged from FCT during the first 4.5 years of FCT field implementation in Maryland (July 2003 to December 2007), and the sample of youth in the comparison group was drawn from all youth discharged during the same timeframe from group homes, therapeutic group homes, and other residential placements offering similar types of services. The average program costs for each youth in group homes ($36,630) and therapeutic group homes ($36,348) were more than 3 times the average program cost of each youth receiving FCT ($12,080) in 2006 ($p < .0001$). Had FCT been unavailable, all youth would have received residential treatment, and the cost for serving those youth would have been $16.3 million. Every $1.00 spent on FCT services for youth saved the State of Maryland between $2.03 and $2.29, for a total estimated savings of $10.9 million to $12.3 million from July 2003 to December 2007.
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.2 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	13-17 (Adolescent)	74% Male 26% Female	59% Black or African American 32% White 8% Hispanic or Latino

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data / Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Recidivism	1.8	2.3	3.0	1.5	2.3	2.5	**2.2**
2: Posttreatment placement	1.8	2.3	3.0	1.5	2.3	2.5	**2.2**
3: Cost-effectiveness	1.8	2.3	3.0	1.5	2.3	2.5	**2.2**

Study Strengths

The archival data obtained for the study are used regularly with the type of population evaluated in the study and have face validity. There were a number of intervention fidelity efforts, including a 95-hour online training and field certification for those administering the intervention, use of 15 adherence measures developed for each family during the treatment process, standards for advancement from one phase of treatment to the next, written session records, and a family satisfaction survey administered at the end of the intervention. Although attrition was high, the rates were relatively equal for the intervention and comparison groups. There were no missing data for the youth included in the analyses. Sophisticated statistical techniques were used to control for selection bias and to reduce variance.

Study Weaknesses

It is not clear whether the organizations from which data were obtained kept accurate records or whether data entry was timely for use in the study. No psychometric data were provided. Attrition rates were above 40% in both the intervention and comparison groups in the second year after treatment. Although the attrition rates were similar in percentage and not uncommon in research with similar youth populations, the high attrition could be a threat to the internal validity of the study. Because participants in the comparison group were matched only on observable differences (e.g., age, gender, type of offense), it is not clear whether participants in the intervention and comparison groups were comparable. Further, since staff, parents, and the courts all had input in determining whether each youth would receive FCT or residential treatment outside of the home, it is unclear how this may have impacted the findings.

Readiness for Dissemination

Review Date: October 2013

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Family Centered Treatment training Web site, http://www.familifirsttraining.org

Institute for Family Centered Services. (2012). Family Centered Treatment annual report. Richmond, VA: Author.

Institute for Family Centered Services. (n.d.). Family Centered Treatment adherence measures. Richmond, VA: Author.

Institute for Family Centered Services. (n.d.). FCT fidelity measures. Richmond, VA: Author.

Institute for Family Centered Services. (n.d.). FCT supervision cover check list. Richmond, VA: Author.

Institute for Family Centered Services. (n.d.). Management supervision video submission form. Richmond, VA: Author.

Institute for Family Centered Services Training Bulletins:

- Areas of Family Functioning (September 2011)
- Engaging Resistant Family Members (February 2005)
- Family Life Cycle Participatory Tool (July 2008)
- Family Roles (December 2007)
- Holiday Seasons (2012)
- Joint Reporting of a Child Protection Complaint (January 2005)
- Preparing for Court (December 2005)
- The ABC's of Spirituality (June 2005)
- The Child Placement Genogram (July 2006)

Painter, W. E. (2011). Executive summary--Family Centered Treatment 2011. Charlotte, NC: FamiliFirst.

Painter, W. E., & Smith, L. (2011). The definitive report on Family Centered Treatment. Charlotte, NC: FamiliFirst.

Painter, W. E., & Smith, M. (2004). Wheels of change: The Family Centered specialist's handbook and training manual. Richmond, VA: Institute for Family Centered Services.

Quality Assurance Director. (2010). FCT quality assurance data collection procedures. Richmond, VA: Author.

Sullivan, M. B., & Thomassen, A. (2011). Training manual for data collection forms: Research and program evaluation (Rev. ed.). Richmond, VA: Institute for Family Centered Services.

Other program documents:

- Client Data Collection Form
- Clinical Performance Report (Samples)
- Core Components Required To Implement Family Centered Treatment
- Descriptive Narrative for Outcome Data Process
- Family Centered Specialist Required Reading List
- Family Centered Therapy Certification Curriculum and Criteria
- Family Centered Therapy Readiness Matrix
- Family Centered Treatment Implementation Timeline: 1st Year [PowerPoint slide]
- Family Centered Treatment Methodology
- Family Satisfaction Survey Receipt Form
- Fidelity Data Spreadsheet Procedures
- IFCS Application for Services
- IFCS Case Review, Map-Issue-Goal-Strategies (MIGS) Form
- IFCS General Discharge Summary Form
- Institute for Family Centered Services Family Satisfaction Survey
- Procedures for Applicant Agency
- The Four Phases of Family Centered Treatment

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	3.9	4.0	**4.0**

Dissemination Strengths

The organizational readiness tools, including the capacity assessment, are helpful and comprehensive. The degree of commitment necessary for an agency to become licensed and its staff to become fully trained is clearly stated. Training materials and support resources are comprehensive and well written, and the training manual is easy to follow. The training requirements before implementation and ongoing supervision and monitoring during implementation strengthen overall quality assurance. Outcome and fidelity measures are available. Ongoing implementation and evaluation support is provided to implementing agencies. Checklists are available for ongoing process and outcome monitoring.

Dissemination Weaknesses

Although the training materials are comprehensive and well written, navigation of the online training platform is not intuitive.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Annual licensing of FCT model	$4,800 per site per year	Yes
On-site implementation readiness assessment and training (includes implementation materials and training of management staff)	$1,750 per site plus travel expenses	Yes

On-site and online staff training and development (includes training of therapists and master trainers)	$20,000-$28,000, depending on the site's needs, plus travel expenses	Yes
Supervisor training and development via Web conferencing, phone, or email or in person (includes online and video or field-based review)	$9,500 per supervisor plus travel expenses if necessary	Yes
Monthly technical assistance and licensure consultation via Web conferencing, phone, or email or in person	$2,500-$3,000 per site per quarter, depending on the site's needs, plus travel expenses if necessary	Yes
Support in producing quarterly reports and monitoring annual fidelity and data outcome adherence	$17,000-$25,000 per site per year, depending on the site's needs	Yes

Additional Information

Therapists are required to become recertified every 2 years. The recertification process supports the review of fundamental practices to help ensure therapist competency. Costs for recertification are included in the monthly technical assistance and licensure consultation cost.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Jaycox, L. H., Hickman, L. J., Schultz, D., Barnes-Proby, D., Setodji, C. M., Kofner, A., et al. (2011). National evaluation of Safe Start Promising Approaches: Assessing program outcomes. Santa Monica, CA: RAND Corporation. Available at http://www.rand.org/pubs/technical_reports/TR991-1

Schultz, D., Jaycox, L. H., Hickman, L. J., Chandra, A., Barnes-Proby, D., Acosta, J., et al. (2010). National evaluation of Safe Start Promising Approaches: Assessing program implementation. Santa Monica, CA: RAND Corporation.

Contact Information

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.familycenteredtreatment.com**