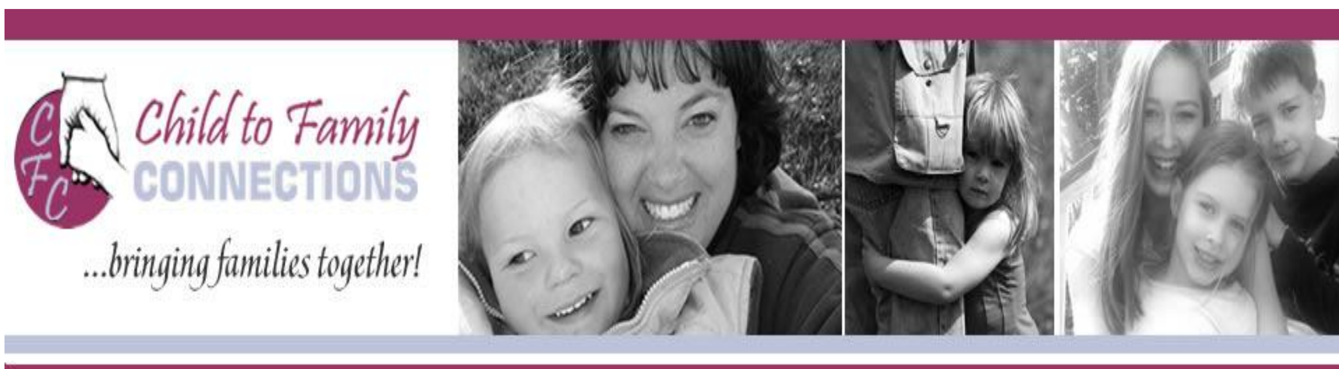
Family Behavioral Therapy: Final Evaluation

Child to Family Connections
(PCCD Subgrant #2007-SE-03 18955)



Child to Family Connections' mission is to partner with individuals and families to recognize their strengths, build relationships, and provide the support and encouragement they need to succeed.

Joseph H. Markiewicz
November 30, 2010

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EVALUATOR CONCLUSIONS

***Objectives*:** This evaluator reviewed the program and implementation protocol for the Family Behavioral Therapy Program according to the national model and examined the training provided for full program fidelity and initial outcome data.

Methods: The evaluation process included meetings with Child to Family Connections staff, interviews with Program Managers/Program Director, review of archival program materials/outcome data, and supplemental materials form the program developer.

Findings: Initial outcomes form the Family Behavioral Therapy Program demonstrates an initial positive effect on families and youth served. The following short-term outcomes have been achieved at the conclusion of the grant period (N=86):

- The average rate of participant attendance has been 70%.
- At discharge, 71% of families reported improved family relationships.
- At discharge, 83% of families reported their mental health improved moderately and /or greatly since their admission to the FBT Program.
- 71% of families reported that they have continued to maintain complete abstinence from drugs/or alcohol in the 90 days post treatment.
- At 90 days post treatment, 71% of families reported that they are no longer open with Children and Youth Services while 29% of families, even though still open with Children and Youth Services, have had their children placed back into their custody in the 90 days post treatment.

Conclusion: It is the opinion of this evaluator that all established protocols for program implementation have been met and the staff has achieved the program outcomes desired by the program developer, including all staffing requirements and adherence

protocols. In addition, there is a substantial cost benefit to the community when in-home prevention programming is utilized that potentially results in huge cost savings by providing a *return on investment* of state and county tax dollars.

Executive Summary

Positive outcomes in families and youth are critical to the future of our communities in the areas of economic stability, positive decision-making, substance abuse, educational attainment, family management skills, positive youth development and other indicators of success. The public health model is based on reducing the risk factors that lead to adolescent problem behaviors and raising the protective factors that buffer families and youth from risk. The Communities That Care (CTC) prevention model has identified the 19 risk factors that correlate to negative youth and family outcomes based on over 30 years of research (Hawkins & Catalano, 1991). For example, the risk factors that correlate with truancy and school drop-out include; transitions and mobility, extreme economic deprivation, family history of the problem behaviors, family conflict, academic failure, lack of commitment to school, anti-social behavior, rebelliousness, early initiation of the problem behavior, and constitutional factors. In short, the more protective factors present in the lives of families and youth, the higher correlation to positive outcomes. According to the CTC prevention model, communities should select evidence-based prevention programs that address these risk factors before the problem behaviors occur in adolescents. This is a proactive approach that is supported in Pennsylvania by such agencies as; Pennsylvania Commission on Crime and Delinquency (PCCD), Pennsylvania Department of Education (PDE), Pennsylvania Department of Health

(DOH), Pennsylvania Department of Health & Human Services (HHS), and many more state organizations.

There are many programs that have been developed to reduce the risk factors related to positive youth outcomes. These programs have numerous titles and varying degrees of scientific evidence to support the claim of successful outcomes for families and youth. Some of various terms used for these programs include; evidence-based, research-based, positive approaches, promising approaches, “what works”, and many other titles. However, many of these programs lack the fidelity and evaluation necessary to substantiate true, long-term positive outcomes for families. True science-based prevention programs must contain three elements to be a research-based program according to most prevention research professionals:

1. The program must be ***replicable*** in any setting; rural, urban, or suburban area.
2. The program has to demonstrate a positive effect ***12 months post-treatment.***
3. The program must have been evaluated ***longitudinally*** by two separate independent evaluators.

There are three well known national organizations for well documented prevention programs with high levels of scientific evidence. They include: the Center for the Study & Prevention of Violence (CSPV), Substance Abuse Mental Health Services Administration (SAMHSA), and the Office of Juvenile Justice & Delinquency Prevention (OJJDP).

Community Needs Assessment: Results of the Pennsylvania Youth Survey

It is important to realize that the Pennsylvania Youth Survey (PAYS) is an accurate, key indicator of the serious issues that affect our families and youth in our communities. Additionally, it is clearly evident that there are *elevated risk factors* that impede the

proper development of our youth, especially in the family domain. Since 1995, The Pennsylvania Commission on Crime & Delinquency (PCCD) has supported a community-based prevention model in Pennsylvania called Communities That Care (CTC). The CTC model is presently operational in over 90 communities across the state and has been extensively evaluated by Penn State University and shown to produce a dramatic reduction of risk factors in youth by applying evidence-based prevention programs. Part of the CTC process involves a community assessment component that allows local community prevention boards to set priority risk factors for their communities based on the results of the Pennsylvania Youth Survey (PAYS). The PAYS survey can show which of the 19 risk factors are at high levels for risk in individual communities. A community prevention board can then implement programs and initiatives to reduce the highest risk factors in youth that eventually lead to; school drop-out, delinquency, teen pregnancy, substance abuse, and violence. There are well established and highly functioning county collaborative boards for both Crawford and Venango Counties (*Children's Advisory Council*, Crawford County and *Focus On Our Future*, Venango County). One of the main functions of these boards is to conduct a community needs assessment (every two years) based on the PAYS Survey and prioritize risk factors for their communities. This allows community-driven prevention efforts to take action on the truly highest risk areas in any given county. For both counties, the Pennsylvania Youth Survey (PAYS) was administered to over 2,000 students in grades 6, 8, 10, & 12 in both counties in 2007. When the data was compiled for both counties, the following *priority risk factors* scored at an elevated level:

1. Poor Family Management (Family Domain)

2. Community Disorganization (Community Domain)
3. Perceived Availability of Handguns ((Community Domain)
4. Laws & Norms Favorable to Drug Use (Community Domain)
5. Peer Rewards for Anti-Social Behavior (Individual Domain)
6. Transitions & Mobility (Community Domain)
7. Family History of Anti-Social Behavior (Family Domain)

Child to Family Connections

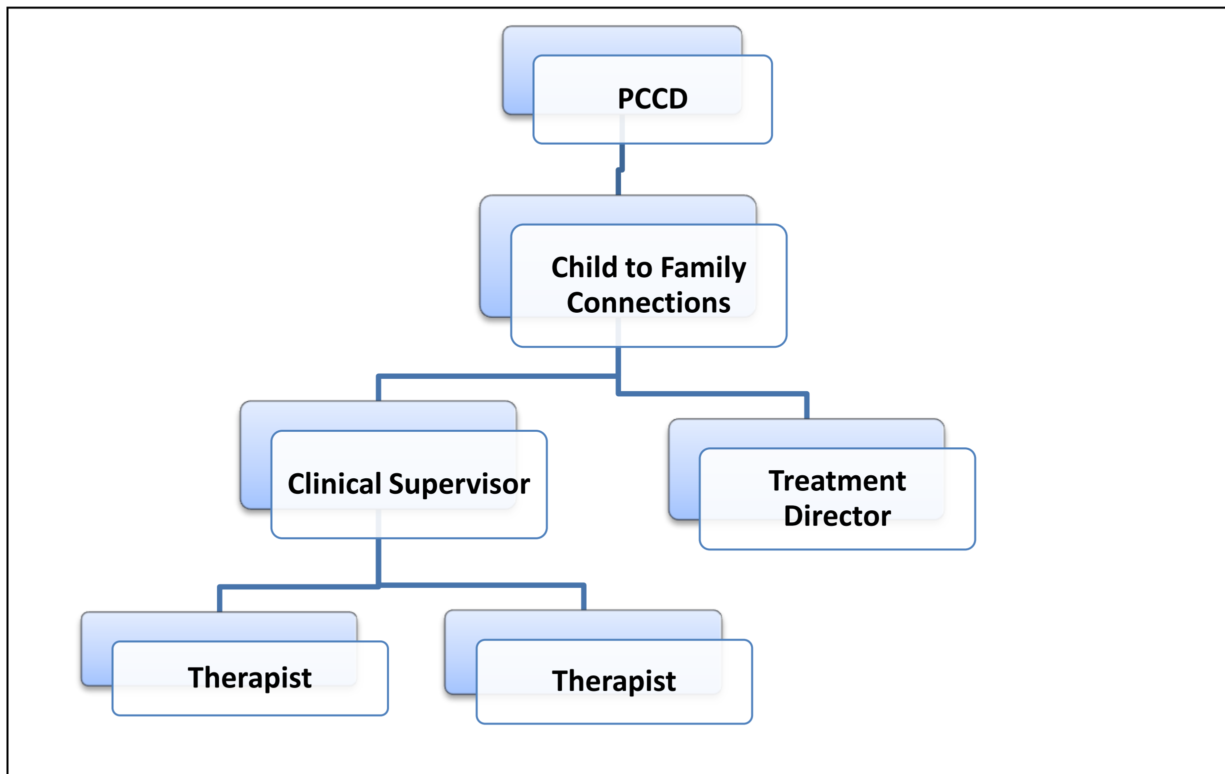
Child to Family Connections (CFC) was founded in 2002 by Director Karen Cross. Child to Family Connections strives to give children who are in the care of a state the authority and the opportunity to live in a loving family environment. They work closely with county and state agencies, including Children and Youth Services, Juvenile Probation, Fostercare systems, and the Statewide Adoption Network (SWAN), to provide a full range of services. Child to Family Connections is a private, fully licensed, non-profit agency committed to finding safe and nurturing environments for all children. Although the staff consists of only a handful of people, they believe and have demonstrated that a small adoption and foster care agency can be more effective than a large agency when it comes to finding homes for children in need. The employees are themselves members of the community, and as such find local homes for local children. The organizational focus is on building on the strengths every family possesses, family reunification, and permanency. In addition, relatives and neighborhood families are called on to assist whenever possible, because they understand the importance of preserving the child's ties with their school district and community. Services provided at Child to Family Connections include:

- Foster Care
- Adoptive Home Studies
- Truancy Program
- Independent Living Program
- Home & Community Habilitation Services
- Family Living
- In-home Counseling
- Parenting/Homemaking
- Supervised Visitation
- Mentoring
- Family Group Decision Making
- Family Behavior Therapy

Pennsylvania Commission on Crime and Delinquency (PCCD) Grant

Child to Family Connections was the recipient of a Substance Abuse Education and Demand Reduction grant from the Pennsylvania Commission on Crime and Delinquency (PCCD) in March 2008. The competitive grant was awarded for the planning and implementation of the Family Behavioral Therapy Program to address alcohol, tobacco, and other drugs rates of usage (ATOD) as well as family risk factors and problem behaviors. The grant monies funded the FBT Program to serve families and youth in the regional area that were most at risk to be placed in residential treatment facilities or families with children in placement to transition their return home. Child to Family Connections was responsible for hiring and training staff, program implementation, process monitoring, arranging ongoing technical assistance, program outcomes, and related grant recipient functions such as required reporting to the Pennsylvania Commission on Crime and Delinquency. A second grant was also awarded to Child to Family Connections from PCCD, but is not addressed in this report. Below is a flow chart explaining the organizational structure of the grant and key program personnel (Chart 1).

Chart 1: Child to Family Connections, Inc. Program Grant Flow Chart



Program Background

Family Behavior Therapy (FBT) is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance, and conduct problems in youth. The development of Family Behavior Therapy was originally funded by the National Institute on Drug Abuse and National Institute of Mental Health. The FBT approach to substance abuse is still one of the only comprehensive scientifically-based approaches to demonstrate improved outcomes in both adolescent and adult substance abuse. This treatment approach owes its theoretical underpinnings to the Community Reinforcement Approach and includes a validated method of improving enlistment and attendance. Participants attend therapy sessions with at least one

significant other, typically a parent (if the participant is under 18) or a cohabitating partner. Treatment typically consists of 15 sessions over 6 months; sessions initially are 90 minutes weekly and gradually decrease to 60 minutes monthly as participants progress in therapy. FBT includes several interventions, including; (1) the use of behavioral contracting procedures to establish an environment that facilitates reinforcement for performance of behaviors that are associated with abstinence from drugs, (2) implementation of skill-based interventions to assist in spending less time with individuals and situations that involve drug use and other problem behaviors, (3) skills training to assist in decreasing urges to use drugs and other impulsive behavior problems, (4) communication skills training to assist in establishing social relationships with others who do not use substances and effectively avoiding substance abusers, and (5) training for skills that are associated with getting a job and/or attending school (NREPP: SAMHSA's National Registry of Evidence-Based Programs and Practices, October. 2006).

FBT Program Implementation and Outcomes

It is the opinion of this evaluator that The Family Behavioral Therapy Program has been implemented with full fidelity as outlined by the program developer. In addition, the technical assistance provided by the program developer has ensured a high quality infrastructure needed to provide all necessary program components. All mandatory trainings have been held along with booster visits from the program developer, regular

staff meetings, and telephone consultation on a monthly basis. The single program modification to the FBT Program was the use of state licensed psychologist as approved by program developer, Brad Donohue, Ph.D. This was confirmed in a letter from Dr. Donohue dated March 9, 2010 (see appendix A). Dr. Donohue approved the staffing modification for the following reasons:

1. The two lead staff members are both licensed mental health professionals who are certified to conduct FBT training.
2. All FBT staff has received extensive training in the program model.
3. The psychologists have extensive training in the family-based therapies which relate to the FBT Program.

To ensure true program implementation fidelity for any evidence-based program, all program staff must receive training and technical assistance from the program developer as prescribed by developer protocols. Below is a summary of the trainings and technical assistance provided for the FBT staff (Table 1).

Table 1: FBT Training and Technical Assistance Summary

Training Provided	Trainer	Attendees	Date
FBT Program (5 days) • Program theory • Program model • Program implementation	Brad Donohue Ph.D.	• Heather Duke, MSW,LSW • Kim Lee, LCSW, MSW	5-15-2008
FBT Program (3 days) • Program implementation	Brad Donohue Ph. D	• Heather Duke, MSW,LSW • Kim Lee, LCSW, MSW	2-13-2009

FBT Booster Visit (3 days) • Program theory • Program model • Program implementation	Brad Donohue Ph. D	• Heather Duke, MSW,LSW • Kim Lee, LCSW, MSW • FBT staff	7-17-2009
Phone consultation **(Duration: 1-2 hours)**	Brad Donohue Ph. D	• FBT staff	Bi-weekly
Technical Assistance	Brad Donohue Ph. D	• FBT staff	As needed
Evaluation	Joe Markiewicz, B.A. Penn State University	• FBT staff	As needed

FBT Program Outcome and Instruments

The FBT Program utilizes five measurement tools to gauge the success of it's clients and family members during curriculum delivery. These tools were designed by the program developer to measure the effectiveness of program delivery as well as the internalization of material by participants. The following is a brief description of each of the five measurement instruments:

1. Adult Adolescent Parenting Inventory
2. Parenting Stress Index/ Short Form
3. Life Satisfaction Scale
4. Parent Satisfaction with Child Scale
5. Eyberg Child Behavior Inventory

1. Adult Adolescent Parenting Inventory

The Adult Adolescent Parenting Inventory (AAPI) was administered to each family at the beginning and end of the Family Therapy Partnership program. The following five factors are used to evaluate parenting skills on the AAPI:

- Factor A-Inappropriate Expectations
- Factor B-Low Level of Empathy
- Factor C-Strong Belief in Value of Corporal Punishment
- Factor D-Reverses Family Roles
- Factor E-Restricts Power Independence

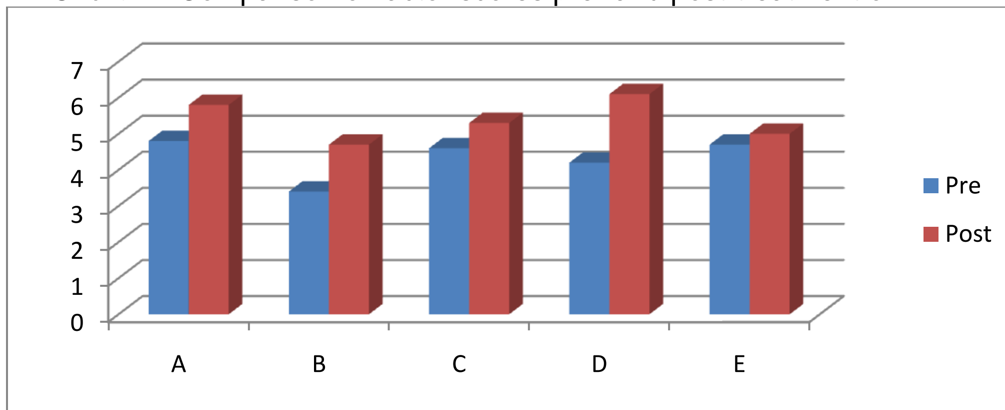
Each factor is scored 1-10. In addition, low scores (1-3) generally indicate a high risk for known abusive parenting practices. High scores (8-10) indicate the expressed parenting attitudes reflect a nurturing, non-abusive parenting philosophy. Mid-range scores (4-7) represent the parenting attitudes of the general population. Scores in the mid-range are preferable and considered average (Table 2).

Table 2: Average scores and differences regarding the five factors of the AAPI

Factor	Initial Average	Closing Average	Within Average?
A	4.80	5.80	YES
B	3.40	4.70	YES
C	4.60	5.30	YES
D	4.20	6.10	YES
E	4.70	5.00	YES

Results: It should be noted that the overall average scores fall mostly within the average range as defined by the AAPI, 4-7. While all families averaged within the normal range, some greatly improved over their experience with the program among certain factors. Among Factors A, B, C, D, and E, there was an overall increase with all families (Chart 2)

Chart 2: Comparison of factor scores pre- and post-treatment on AAPI



2. Parenting Stress Index/ Short Form (PSI/SF)

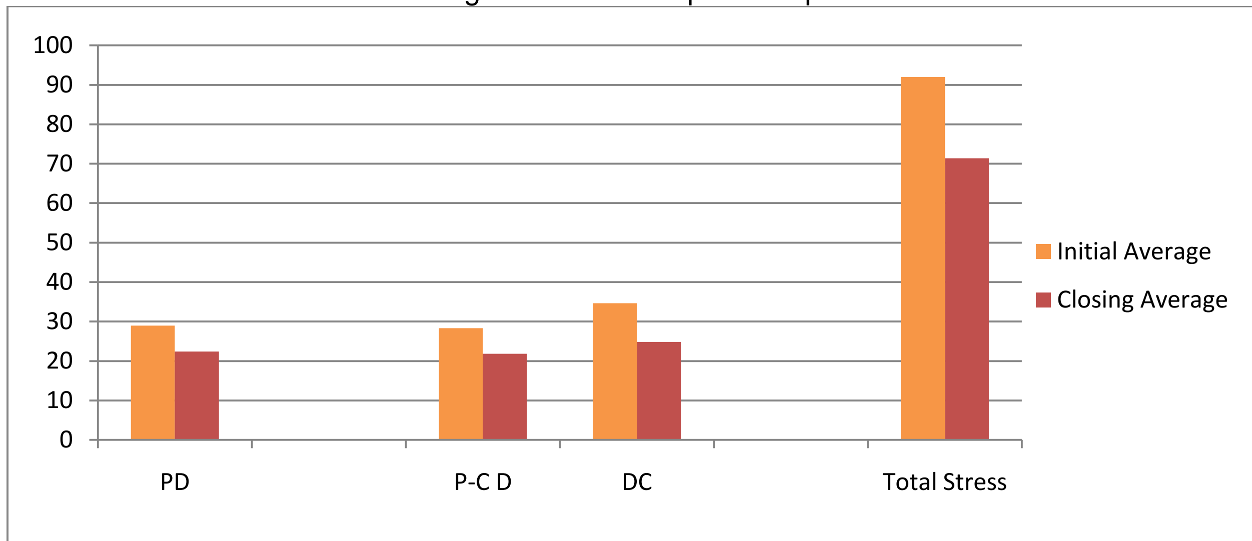
The PSI/SF is a direct derivative of the Parenting Stress Index full length test. It consists of 36 items and is designed for the early identification of parenting and family characteristics that fail to promote normal development and functioning in children, of children with behavioral and emotional problems, and of parents who are at risk for dysfunctional parenting. The PSI/SF has three subscales labeled: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. The Parenting Stress Index was administered to clients at the beginning and at the end of the program. In general, the normal range for scores is within the 15th to 80th percentiles. High scores are considered to be scores at or above the 85th percentile and are said to be experiencing clinically significant levels of stress (Table 3).

Table 3: Average scores and differences regarding stress subscales and total stress

Subscales	Initial Average	Closing Average	Within Average?
Parenting Distress	29.00	22.40	YES
Parent-Child Dysfunctional Interaction	28.30	21.80	YES
Difficult Child	34.66	24.80	YES
Total Stress Score	92.00	71.40	YES

Results: It should be noted that the initial total stress score fell above the 85th percentile and deemed as clinically significant levels of stress. Upon completion of the program, the total stress score average fell 20 percent to the 71.40th percentile, within normal range of the PSI/SF (Chart 3).

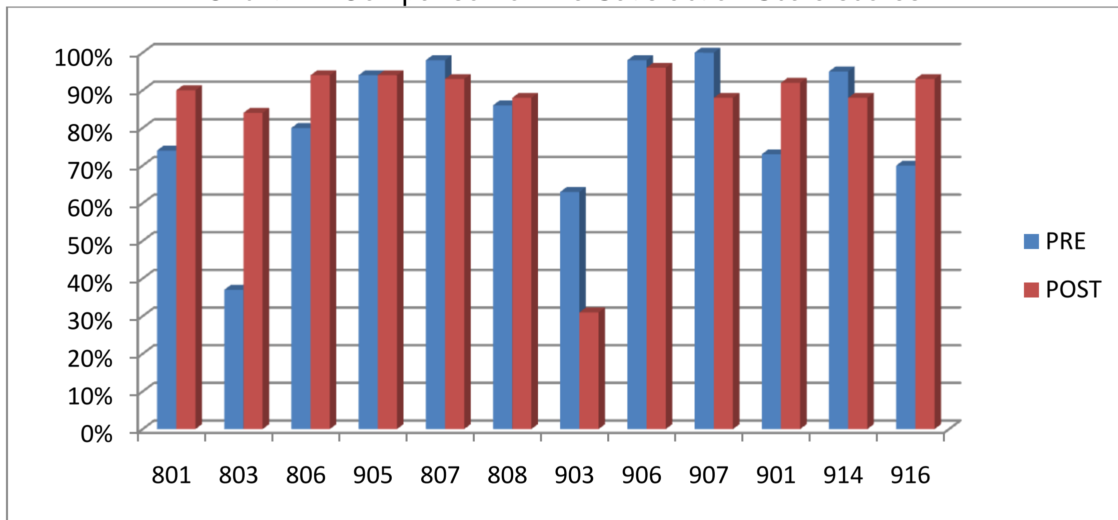
Chart 3: Average scores of PSI pre- and post-treatment



3. Life Satisfaction Scale

The Life Satisfaction Scale (LSS) includes 12 content items, and a single item that requires clients to rate their "overall life satisfaction." Content items assess the respondent's degree of happiness in 12 aspects of life (i.e. friendships, family, school, employment/work, fun activities, appearance, sex life/dating, drug use, alcohol use, money/material possessions, transportation, control over one's life) using a 0% to 100% scale of happiness. The instrument's simplicity enables it to be easily understood by clients, and its brevity permits it to be implemented throughout the course of treatment. The LSS is administered at the start and end of treatment (Chart 4).

Chart 4: Comparison of Life Satisfaction Scale scores.



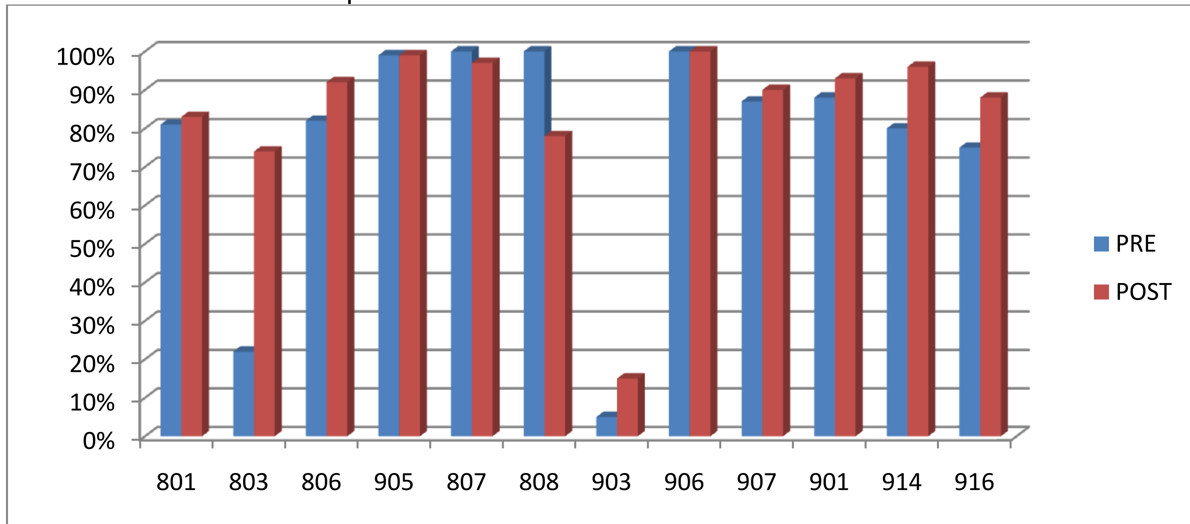
Results: The average pre-treatment LSS score was 81 percent while the average post-treatment score was 86 percent. It should be noted that 66 percent of clients reported an increase in their life satisfaction while 33 percent of clients remained unchanged or reported a decreased satisfaction in life. Client 0807 reported a low satisfaction (0%) with his educational level at discharge after some unsuccessful job interviews but it is important to note that even though client 0807 reported a decrease in life satisfaction, the score at discharge was still 93 percent overall satisfaction which is statistically significant. Client 0903 reported a lower life satisfaction at discharge after her husband was in a traumatic accident and had relapsed into daily drug use which merited a need for additional treatment post discharge from the program.

4. Parent Satisfaction with Child Scale

The Parent Satisfaction with Child Scale (PSCS) includes 12 content items that require clients to rate how happy they are with their child(ren). Content items assess the respondent's degree of happiness with their child in many areas of life (i.e. communication, relationship, child's reaction to praise and attention, compliance, family

involvement, etc) using a scale of 0% to 100% scale of happiness. The PSCS is administered at the start and end of treatment (Chart 5).

Chart 5: Comparison of Parent Satisfaction with Child Scale scores.



Results: The average pre-treatment PSCS score was 77 percent while the average post-treatment score was 84 percent. Sixty-six percent of clients reported an increase in their satisfaction with their child post treatment while 33 percent of clients reported their satisfaction with their child decreased over the course of treatment; it should be noted that both client's child (0807, 0808) was an infant at the beginning of treatment and grew to be 12-15 months old at termination. This fact is significant in that when respondents were asked about their post-treatment satisfaction scores, they reported that their child was more active and required more of their time at termination. Their post-treatment satisfaction scores were 97% and 78% respectively compared to 100% parent-child satisfaction at the beginning of the program.

5. Eyberg Child Behavior Inventory

The Eyberg Child Behavior Inventory (ECBI) lists 36 disruptive behaviors, and the parent indicates on a seven-point scale (never to always) how often the child exhibits

each behavior (i.e. Intensity scale). A Problem scale is also derived to assess whether or not the parent perceives each behavior as problematic (1, yes; 2, no). Eyberg and Pincus (1999) indicate the reliability as excellent and its validity is adequate. When the Intensity scale is low, but the Problem scale is elevated, clients require assistance in understanding child development. When Intensity scores are elevated, and Problem scales are low, it may be important to encourage appropriate expectation and disciplinary strategies. The Eyberg Child Behavior Inventory is administered at the beginning and end of treatment (Table 4).

Table 4. ECBI t-scores

	INTENSITY SCALE		PROBLEM SCALE	
Client	Pre	Post	Pre	Post
0801	48	40	45	46
0803	59	65	64	63
0806	42	37	42	0
0807	42	34	5	0
0808	42	39	2	0
0905	42	35	51	0
0903	84	77	85	84
0906	N/A	37	N/A	41
0907	44	40	41	41
0901	58	60	41	1
0914	N/A	N/A	N/A	N/A
0916	67	51	69	0

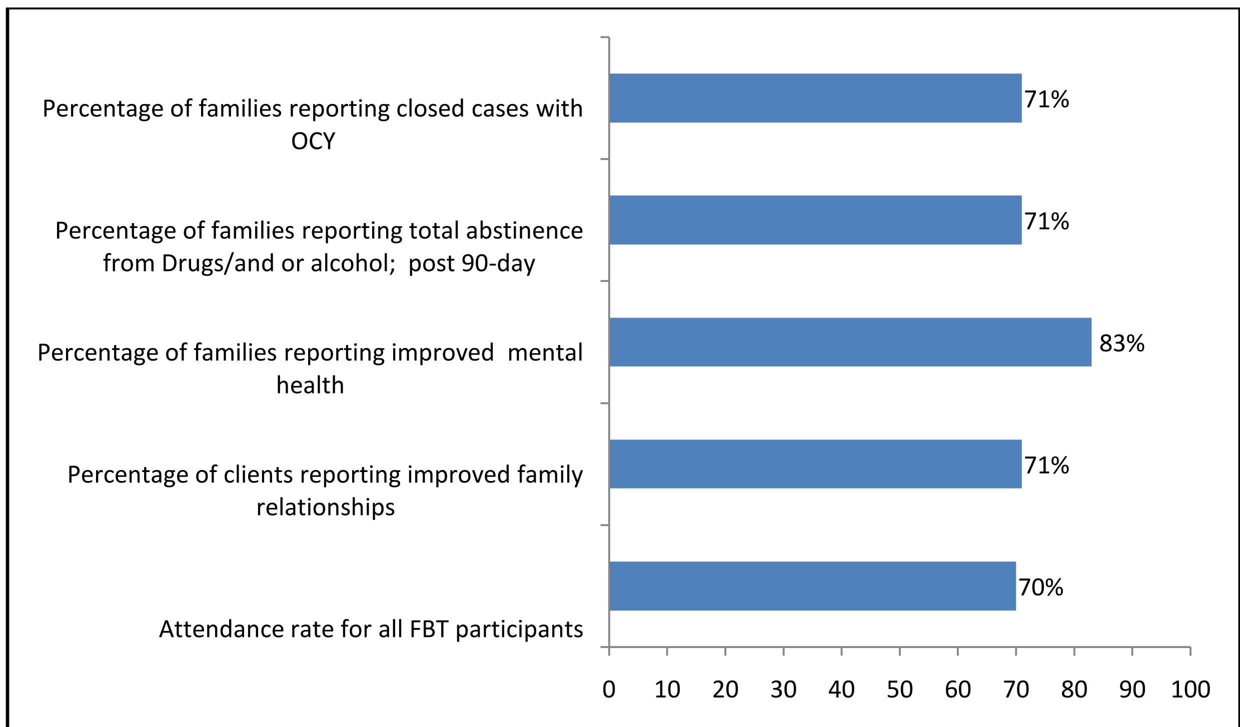
Results: It should be noted that 78 percent of clients reported a decrease in the frequency of disruptive behaviors exhibited by the child while 66 percent of clients reported a decrease in their problem scale upon discharge. At time of discharge, 78 percent of clients reported a decrease of disruptive behaviors on the intensity and/or problem scale which represents significant improvements in their understanding of child development, appropriate expectation, and/or child disciplinary strategies. Pre-scores

for client 0906 and pre/post scores for client 0914 were not available due to child being too young for scale to be effective at pre- and post-assessment.

Family Behavioral Therapy Program Outcomes 2010

It has been previously established that the Family Behavioral Therapy Program has been implemented with full fidelity as prescribed by the program developer, Dr. Brad Donohue. The scope of this evaluation report serves to analyze the process and short-term outcomes of the Family Behavioral Therapy Program that was implemented by Child to Family Connections, with state funding from the Pennsylvania Commission on Crime and Delinquency. A summary of these outcomes are listed in Chart 6 (below).

Chart 6: Program Outcomes



Family Behavioral Therapy Program: A Cost Benefit Analysis

There has been much research demonstrating the huge economic cost savings to communities that address the risk factors that lead to problem behaviors in adolescents. Communities that address these risk factors can show an economic impact in future cost savings in the form of tax dollars spent on incarceration, lower salary earnings, medical benefits and many other factors. The economic cost to the average taxpayer in Pennsylvania to remove a youth from home for any number of dysfunctional home situations is staggering. In addition, youth who fail academically because of family-related dysfunctions are at elevated risk to become in involved in the same problem behaviors (D&A use, etc), drop out of school, and become a life-long burden on the county and state tax base. In short, youth who come from dysfunctional family situations and fail to gain even a basic education in high school do not add to the local tax base and require government assistance in the following forms:

- Welfare
- Food Stamps
- Federal SSI
- Unemployment Insurance
- Medicare/Medicaid
- Drug & Alcohol Treatment
- School Lunch Program
- Energy Assistance
- CJ Resources
- Lower wage earnings
- Social Security

Furthermore, students who do not graduate from school earn considerably less income over the course of their lifetime resulting in lower tax base earnings and more reliance on the public welfare system. Many social scientists refer to school drop-out as the *"school-to-prison" pipeline* because many young adults enter the adult criminal justice system as a result of lower earning potential and lack of income. Listed below are some key examples of the high costs of adolescent problems that carry over into adulthood:

- The average lifetime costs incurred for a student who drops out of high school is approximately $400,000 per student *(Mark Cohen, 1998).*
- The average cost of keeping an adjudicated youth in a secure facility for delinquency in Pennsylvania is $140,000 per year and $54,000 per year in a non-secure facility. The total price tag for placing youth in these facilities in Pennsylvania in 2006 is $187 million *(2009 Annual Report, Pennsylvania Commission on Crime and delinquency).*
- The average lifetime cost for a youth who becomes involved in drug and alcohol treatment services (and related services) is approximately $970,000 per student *(Cohen, 1998)*
- The average lifetime costs incurred for a youth who becomes incarcerated and a career criminal is estimated between $1.5 to 3.5 million *(Cohen, 1998).*

The total program cost for all four years of the FBT Program was approximately $240,000, and provided services for eighty-six clients. This would factor out to approximately $2,790 per family (not individual). For the purposes of this cost estimate, the cost benefit is only calculated using one youth per family, thus the actual cost savings are substantially higher. A cost benefit ratio can be calculated by comparing

the potential costs savings in government tax dollars (grant monies) to the potential cost savings for the youth who was diverted from a particular problem behavior (i.e., D&A use, school drop-out, incarceration, etc). For example, based on the fact that the lifetime cost associated with a high school drop-out averages $400,000, it is practical to calculate dollars invested versus dollars saved. Comparing the cost of providing FBT programming to one student ($2,790), the cost benefit ratio is $143:1. **That means for every successful youth that stays in school as a result of the FBT program, there is a $143 return on investment for every dollar invested with grant monies.** In addition, every student who stayed in school as a result of the FBT program, there is a minimum of $400,000 cost savings to the community in future costs over his/her lifetime. If there are more than just one successful student, the cost savings would be multiplied by the number of students. **Hypothetically, if five students were successful in the FBT program and did not drop out of school, the potential return on investment would be $1 million in future related costs.** These examples are only being demonstrated for the problem behavior of school drop-out. If a cost benefit analysis was conducted for drug and alcohol addiction or incarceration, the cost savings would potentially be much greater. These services tend to be long-term in nature and are accompanied by high recidivism rates (reoffending). Based on previous studies (Mark Cohen), the economic costs incurred for these problems is substantial. **An estimation of the potential cost savings for five successful youth in the area of drug and alcohol addiction would have a cost benefit in the amount of approximately $4.8 million over the lifetime of the five students.** As discussed previously, this includes costs related to treatment services, lack of income, medical

benefits, food and housing support, etc. When discussing career criminality and long-term incarceration, even the prevention of two youth from entering the adult justice system has a potential cost savings of approximately in the range of $3 million to $7 million. In short, evidence-based prevention programs, similar to Family Behavioral Therapy, are very cost effective for the monies that are dedicated to program implementation and operation. They are both highly effective and pay a huge return on investment economically.

Family Behavioral Therapy Program Summary/Recommendations

It is the opinion of this evaluator that the Family Behavioral Therapy Program has been implemented with full fidelity by the lead agency Child to Family Connections, Inc. All program components have been incorporated as specified by the program developer, and the Family Behavioral Therapy staff continues to receive ongoing technical assistance as needed from the program developer. Furthermore, for the successful sustainability of this program, the following recommendations are being made to assist this project for full viability and continuation:

1. In addition to the existing short-term outcomes, a review team be created to develop **middle and long-term goals** that are measurable and achievable for program recipients. These goals would be measureable, but also realizing that long-term outcomes in youth could take 6-8 years or more to occur.
2. It is also recommended that some of the **past program recipients** be involved with future direction, planning, and expansion of the present FBT Program as it develops. The feedback and insight from actual program participants would be a great strength for program feedback (strengths/growths).

3. Family Behavioral Therapy Program staff conduct a **SWOT (Strengths/Weaknesses/Opportunities/Threats) analysis** of the program and its current state. This could provide valuable insight and future direction for program sustainability and possible expansion efforts.
4. A viable, realistic **Sustainability Plan** be developed for the Family Behavioral Therapy Program that would include:
    a. Program background and history.
    b. Agency background and history.
    c. County collaborative board (Children's Advisory Council)
    d. Current funding and future potential funders
    e. Program objectives and long term goals

Appendices

Appendix A: FBT program developer letter for curriculum modification

Appendix B: FBT participant testimonial letter

Appendix C: Public Health Model Risk Factor Matrix

Appendix D: References

Appendix A:

FBT program developer letter for curriculum modification

Appendix B:

FBT participant testimonial letter

Appendix C:

Public Health Model Risk Factor Matrix

Appendix D:

References

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