

State Adolescent Treatment
and Enhancement and
Dissemination (SAT- ED)

Final Project Report



THE IOWA CONSORTIUM FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

**Final Project Report
March 2016**

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CONSORTIUM**
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**Donna Lancianese, PhD
Senior Program Evaluator**

**Heather Hershberger, MPP
Program Evaluator**

**Stephan Arndt, PhD
Director**

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EXECUTIVE SUMMARY

The Iowa Department of Public Health (IDPH) was awarded a three-year grant funded through the State Adolescent Treatment, Enhancement, and Dissemination (SAT- ED) program from the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish the SAT- ED Families in Focus project. The goals of this grant included moving toward a more coordinated effort to serve adolescents and their families and to expand and enhance the state's adolescent treatment services. This is being achieved by implementing Multi-Dimensional Family Therapy (MDFT), an evidence-based practice and the Comprehensive Adolescent Severity Inventory (CASI), an evidence-based assessment tool. Goals also included development of Iowa's professional workforce by providing MDFT and CASI training to staff, as well as conducting a process and outcome evaluation.

The SAT- ED Families in Focus project began in Iowa in October 2012 with two substance use treatment agencies: Prairie Ridge Integrated Behavioral Healthcare (Prairie Ridge) in Mason City and Youth and Shelter Services (YSS) in Ames. In Year Two, two additional treatment providers were added to the project: Prelude Behavioral Services (formerly MECCA) in Iowa City and Heartland Family Services (HFS) in Council Bluffs. A six-month no-cost extension was awarded through March 31, 2016. Agencies continued admitting clients to the grant until September 30, 2015. The no-cost extension allows the Focus Centers and treatment providers to continue treating all active MDFT clients. The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducts the evaluation for the SAT-ED Families in Focus project. This Final Project report examines activities and outcomes from October 1, 2012 through January 31, 2016.

MDFT and CASI Training

As of January 31, 2016, 23 therapists have been trained or are working towards MDFT certification (four of those are no longer employed with the four sites). In order to become an MDFT supervisor, the staff person must first be MDFT certified, and in order to become an MDFT trainer, the staff person must first become an MDFT supervisor. Of the 19 staff members still active and trained in MDFT, eight either completed or will complete MDFT supervision certification. Four MDFT supervisors are currently MDFT trainers. The project is above target for achieving the sustainability objective to train a team of 18 certified MDFT therapists, six certified MDFT supervisors, and two statewide MDFT trainers. Twenty-two staff from the four sites have been trained in the use of the CASI assessment (four are no longer employed with the four sites). Therapists use this tool to screen if the adolescent is appropriate for MDFT.

Adolescent Characteristics

IDPH Central Data Repository (CDR) data were used in the analyses. There are 131 adolescents reported here.

Age and Sex: Adolescents in the SAT-ED Families in Focus project range from 10 to 18 years of age; the majority of adolescents are 16 or 17 years of age with a median age of 16. Nearly two-thirds (64.9%) of the adolescents are male and over one-third (34.4%) are female.

Race and Ethnicity: The majority of adolescents are White (94.4%). Three adolescents (2.3%) are African American. The project has served two adolescents that are American Indian



(1.5%). Four and six-tenths percent of the clients reported themselves as Mexican, 1.5% reported Puerto Rican, and 3.8% reported themselves as other Hispanic or Latino.

Substance Use at Admission: All adolescents reported a primary substance at admission; marijuana was the most common primary substance reported by 67.5% of the adolescents, followed by alcohol (22.1%). Fifty-one adolescents (38.9%) indicated substance use one to three times in the past month. Thirty-seven (28.2%) adolescents reported no use in the past month. Only 5.3% reported using once daily.

Co-Occurring Disorders: Records indicate 104 of the 131 adolescents (79.4%) have co-occurring disorders.

Rural Youth Participation: There are a few clients from rural counties in Iowa: 16 out of 131 adolescents (12.2%).

Treatment Completion Status

Of the 131 adolescents used in this report, there were 112 discharge records in the Central Data Repository (CDR) as of January 31, 2016. Of the 112 discharged clients, two-thirds (70 clients, 62.5%) successfully completed treatment, 22 (19.6%) were terminated, and 20 (17.9%) were neutrally discharged. Length of stay in treatment ranged from zero to 449 days with a median length of stay of 128 days for those discharged adolescents.

Discharge Status	N=112	Percent
Success	70	62.5%
Treatment Plan Completed	51	45.5%
Treatment Plan Substantially Completed	19	17.0%
Terminated	22	19.6%
Program Decision Due to Lack of Progress/Compliance	3	2.7%
Client Left	19	17.0%
Neutral	20	17.9%
Referred Outside	12	10.7%
Incarcerated	2	1.8%
Other	6	5.4%



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BACKGROUND

In October 2012, the Iowa Department of Public Health (IDPH) was awarded a three-year-grant funded through the State Adolescent Treatment, Enhancement, and Dissemination (SAT-ED) program from the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish the SAT- ED Families in Focus project. The State of Iowa intends to achieve four goals as a result of this grant:

- Support Iowa's behavioral health providers in moving toward a more coordinated effort to serve adolescents and their families.
- Expand and enhance family treatment.
- Develop Iowa's professional workforce.
- Conduct a process and outcome evaluation.

The SAT-ED Families in Focus Project began in Iowa in October 2012 with two Focus Centers: Prairie Ridge Integrated Behavioral Healthcare (Prairie Ridge) in Mason City and Youth and Shelter Services (YSS) in Ames. In Year Two, two additional treatment providers were added to the project: Prelude Behavioral Services (formally known as MECCA) in Iowa City and Heartland Family Services (HFS) in Council Bluffs. The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducts the evaluation for the SAT- ED Families in Focus Project.

The four sites implemented Multi-Dimensional Family Therapy (MDFT), an evidence-based practice chosen by the State of Iowa to help expand and enhance the state's adolescent treatment services. Prior to involvement in MDFT, Focus Center staff administer the Comprehensive Adolescent Severity Indicator (CASI) to potential project clients. This evidence-based assessment tool identifies whether the adolescent and family are suitable for MDFT. A six-month no-cost extension was awarded through March 31, 2016. Agencies continued taking clients until September 30, 2015. The no-cost extension allows the Focus Centers and treatment providers to continue treating all active MDFT clients. This Final Project report examines activities and outcomes from October 1, 2012 through January 31, 2016.

DATA COLLECTION AND MANAGEMENT SYSTEMS

Data Collection

Focus Center and treatment provider staff collect client self-reported data using the Government Performance and Results Act (GPRA) for adolescents at admission, discharge, and six months post-admission (follow-up). Initially, GPRA data were entered into the United States Department of Health and Human Services CSAT-GPRA Services Accountability Improvement System (SAIS). SAMSHA transitioned from SAIS to the Common Data Platform (CDP) in March 2015. Staff entered data into the CDP until July 2015 when SAMHSA discontinued the CDP system. Focus Center and treatment provider staff continue to complete GPRA's and submit them to the evaluator. These data will be entered in the SAIS system, at a date yet to be determined. In addition to GPRA data, the Consortium utilizes client treatment admission data from IDPH's Central Data Repository (CDR). The CDR contains all of the state required substance use disorder treatment admission and discharge data in Iowa. Since GPRA data are currently unavailable, this report uses data exclusively from the CDR. All information in this report is based on CDR data downloaded after the end of the cut-off date of January 31, 2016.



The evaluator created a Family Participation form for the Focus Centers and treatment providers to track the total number of sessions attended by each adolescent and those sessions attended by the adolescent's family members. Focus Centers and treatment providers submit this form to the evaluator within seven days of the adolescent's discharge from the grant.

Focus Centers and Year Two treatment providers implemented the Family Global Outcome Measure and the Adolescent Global Outcome Measure in February 2015. The therapist or therapist assistant administered this instrument to clients and family members via the telephone approximately six months after discharge from the grant. The project design allowed staff to conduct the measure anywhere from two weeks prior to 28 days after the six month post-discharge date. The Global Outcome Measures include questions regarding overall improvement of the adolescent's family interactions, substance use, mental health, and peer relations.

MDFT Clinical Management System

The MDFT originators developed a web-based clinical management system that became available during Year Two (MDFT Clinical Portal). This is a web-based management system designed to facilitate therapist, supervisor, and therapist assistant fidelity to MDFT; to enhance implementation of MDFT; and to provide a system of monitoring and accountability to allow MDFT International to provide technical assistance and support. Data from the MDFT Clinical Portal are used to provide annual MDFT implementation reports for Focus Centers and Year Two providers at the request of the evaluator. The data from these reports are used by the Associate Director from MDFT International to ensure fidelity of those being trained.

PROJECT IMPLEMENTATION

Multi-Dimensional Family Therapy (MDFT) is the evidence-based practice chosen by the State of Iowa to help expand and enhance the states' adolescent treatment services. Certification requires six months of intensive training that includes several on-site trainings, weekly and bi-weekly phone calls with MDFT trainers to review cases and assist with case planning, DVD supervisions and live supervisions at site visits by MDFT trainers, written examinations, and work samples. Follow-up MDFT trainings were held at each treatment agency to complete the training process.

During the follow-up trainings, the MDFT trainers and therapists participated in two days of case review, consultation, and live supervision. Live supervision sessions consisted of one hour preparation and planning for the session, an actual family therapy session, and a half hour post session debriefing. The Focus Center therapists and trainers watched the sessions live. MDFT trainers communicated directly to the therapist in sessions to provide guidance or direction if necessary.

The MDFT therapist training certification was completed on average within six months of the initial training. Some therapists completed the process over longer periods due to timing of cases and case review submissions. Once certified in MDFT, the client caseload can increase up to eight adolescents for full-time therapists.

Each Focus Center initially assigned two therapists, one treatment supervisor, and a project therapist assistant to the project, along with support from other staff as warranted by the



adolescents' treatment plans or grant management needs. During Year One, staff at IDPH and the two Focus Centers developed the implementation plan. This centered on identification of key staff, scheduling trainings, conference calls, and contractual compliance.

The initial MDFT training took place in January 2013 for one treatment supervisor from each Focus Center to become an MDFT supervisor. These supervisors underwent a process similar to that for regular certification, with regular contact with the trainer and review of techniques. This process continued for a minimum of six months. At the beginning of Year Two, the trained MDFT supervisor left YSS. The remaining MDFT trained supervisor at Prairie Ridge was able to provide supervision for the other agencies that were still in process of completing MDFT certification. Three therapists from each Focus Center (YSS and Prairie Ridge) attended the initial training. A follow-up MDFT training took place at each agency during July 2013 to complete the training process for certification.

Training efforts continued in Year Two with the addition of the two treatment providers (Heartland and Prelude). Implementation efforts in Year Two focused on workforce expansion and sustainability by adding additional trained staff for MDFT at the two additional treatment provider sites; training took place in February 2014. In Year Three, the Focus Centers and the treatment providers added more MDFT certified therapists, supervisors, and three new trainers as a result of additional training.

The CASI is an evidenced-based, comprehensive, semi-structured, clinical assessment and outcomes interview chosen by the State of Iowa as part of this project. The interview questions include health, family, stressful life events, legal status, sexual behavior, alcohol and other drug use, mental health functioning, peer relationships, education, and use of free time. Training included therapists attending a two-day training session, passing a post-training proficiency measure and passing a follow-up proficiency measure. The initial CASI training was held in March 2013 with the two Focus Centers. After the initial CASI training, two therapists from each Focus Center attended another two day training to become CASI certified trainers. CASI training was held in January 2014 and January 2015 for staff at all four sites. In order to assist trainers in Iowa in training new CASI clinician's, an on-line training program was developed in Year Three. Trainees trying to become CASI certified for the first time must complete the on-line training and then have two site visits with an Iowa trainer. The first site visit is right after the on-line training and the second a few months later, which allows the clinician to practice.

Staff Certifications

As of January 31, 2016, 23 therapists are MDFT certified and four of those are no longer employed with the sites. In order to become an MDFT supervisor, staff must first be MDFT certified therapists, and in order to become an MDFT trainer, staff must first become MDFT supervisors. Of the 19 staff members still active and trained in MDFT, eight either completed or will complete MDFT supervision certification. Four MDFT supervisors are currently MDFT Trainers. The project is above target for achieving the sustainability objective to train a team of 18 certified MDFT therapists, six certified MDFT supervisors, and two statewide MDFT trainers.

Twenty-two staff from the four sites are trained in the use of the CASI assessment (four are no longer employed with the four sites). Therapists use this tool to screen if the adolescent is appropriate for MDFT. In addition, YSS is utilizing the CASI throughout their service area, including using it with clients that are not in the SAT- ED Families in Focus Project.



Table 1 shows the number of currently active MDFT and CASI trained staff working with the SAT- ED Families in Focus project. Of the 19 MDFT certified therapists, two (10.5%) are male and 17 (89.5%) are female. The majority of MDFT therapists (94.7%) are White and one (5.3%) is African American.

Table 1. Number of Currently Active MDFT Trained Staff and CASI Certified in the SAT- ED Families in Focus Project by Year

Staff Trained by Year*	MDFT Staff	MDFT Supervisor	MDFT Trainer	CASI
Year 1	4	0	0	4
Year 2	5	3	1	7
Year 3	10	4	3	7
Total	19	7	4	18

*This includes staff who have completed and who are on track to complete certification

Intake Rate

The evaluator received GPRA intake data for 111 clients. During Year Three, IDPH staff discovered there were an additional 22 clients who received SAT-ED grant services, however GPRA intakes were not administered with these 22 clients. As guidance from the previous Center for Substance Abuse Treatment Government Project Officer stated, these 22 clients could not be counted as services did not occur at one of the original project sites, however, IDPH still believed that data obtained for services provided to those individuals was beneficial to measuring overall grant performance. One hundred thirty-one clients were admitted to SAT-ED through January 31, 2016. Eight of the 111 clients were admitted for services a second time. However, adhering to SAMHSA guidelines, clients only count once toward reaching the target number of clients and the most recent admission record is used for re-admitted clients. The number of intakes, using either the GPRA intakes (111) or the total intakes (131), are below the overall target (165), as shown in Table 2.

Table 2. Total Intakes

Program Intakes		Percent of Target (165)
GPRA Intakes	111	67.3%
Additional Intakes	22	
Total Intakes	131	79.4%

Follow-Up Rate

Adhering to GPRA guidelines, follow-up interviews are conducted within a period of 30 days before and up to 60 days after the six-month post-admission date. According to information received by the evaluator from the Focus Centers and treatment providers as of January 29, 2016, 82 follow-up interviews were completed with clients six months post-admission as shown



in Table 3. This only takes into consideration the 111 intakes because these have GPRA admission data and the additional 22 clients do not.

Table 3. Total Follow-up Rate

Follow-Ups Completed	Six-month Follow-Ups Due	Follow-up Rate
82	104	78.8%

CLIENTS

Description of Adolescents at Admission

Tables 4 and 5 present sex and age of clients at admission. Of the 131 adolescents admitted to the project, 85 (64.9%) are male, 45 (34.4%) are female, and one adolescent's sex was coded as unknown. Adolescents range from 10 to 18 years of age; the majority of adolescents are 16 or 17 years of age with a median age of 16.

Table 4. Adolescent's Sex at Admission

Gender	All Adolescents % (N=131)
Male	64.9 (85)
Female	34.4 (45)
Unknown	0.8 (1)

NOTE: Percentages may not add up to exactly 100% due to rounding

Table 5. Adolescent's Age at Admission

Years of Age	All Adolescents % (N=131)
Ten	0.8 (1)
Twelve	0.8 (1)
Thirteen	5.3 (7)
Fourteen	11.5 (15)
Fifteen	16.0 (21)
Sixteen	32.1 (42)
Seventeen	30.5 (40)
Eighteen	3.1 (4)

NOTE: Percentages may not add up to exactly 100% due to rounding.



Table 6 presents primary race reported at admission. The majority of adolescents are White (93.9%), three adolescents (2.3%) are African American, and two adolescents (1.5%) are American Indian.

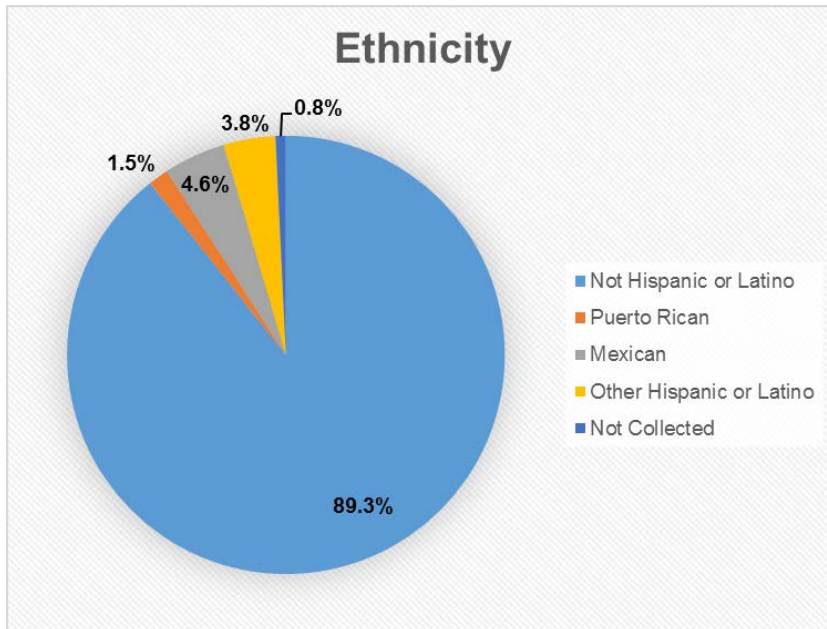
Table 6. Adolescent's Race

Race	All Adolescents % (N=131)
White	93.9 (123)
African American	2.3 (3)
American Indian	1.5 (2)
Unknown	0.8 (1)
Not Collected	0.8 (1)
Missing Data	0.8 (1)

NOTE: Percentages may not add up to exactly 100% due to rounding.

Figure 1 shows ethnicity reported at admission. The majority of adolescents (93.5%) reported that they were not Hispanic or Latino.

Figure 1. Adolescent's Ethnicity



Rural counties are defined as populations less than 2,500¹. Of the 131 clients, there are few clients from rural counties in Iowa (16), as shown in Table 7.

¹ As defined by U.S. Census Bureau, Population Division, Office of Management and Budget, February 2013 delineations.

Table 7. Rural Clients

Rural	All Adolescents % (N=131)
No	87.8 (115)
Yes	12.2 (16)

Substance Use Reported at Admission

Marijuana was, by far, the most frequently reported primary substance among the adolescent clients (69.5%) as shown in Table 8. Nearly a quarter of all clients (22.1%) reported alcohol as their primary substance. Of the 131 clients, clients most commonly reported using their primary substance one to three times in the past month (38.9%), 28.2% reported no use in the past month, and only 5.3% reported using once daily, as shown in Table 9. A secondary substance was reported by 81.7% of the clients at admission. Alcohol was the most commonly used secondary substance at admission (51.2%).

Table 8. Primary Substance at Admission

Primary Substance at Admission	All Adolescents % (N=131)
Marijuana	69.5 (91)
Alcohol	22.1 (29)
Methamphetamines	3.1 (4)
Benzodiazepines	2.3 (3)
Cocaine/Crack	1.5 (2)
Other Opiates and Synthetics	.8 (1)
Other Sedatives/Hypnotics	.8 (1)

NOTE: Percentages may not add up to exactly 100% due to rounding.

Table 9. Frequency of Use

Frequency of Use	All Adolescents % (N=131)
4 or More Times Daily	2.3 (3)
2 to 3 Times Daily	3.1 (4)
Once Daily	5.3 (7)
3 to 6 Times Per Week	6.1 (8)
1 to 2 times per week	9.9 (13)
1 to 3 times in the past month	38.9 (51)
No use in the past month	28.2 (37)
No use in the past 6 months	4.6 (6)
Unknown	1.5 (2)

NOTE: Percentages may not add up to exactly 100% due to rounding.



Co-Occurring Disorders

At admission, Focus Center and treatment provider staff indicate if clients have a psychiatric problem in addition to an alcohol or drug problem. As shown in Table 10, staff reported 104 clients (79.4%) had a co-occurring disorder.

Table 10. Screening Results for Co-Occurring Disorders

Co-Occurring Disorder	All Adolescents % (N=131)
Yes	79.4 (104)
No	20.6 (27)

DISCHARGE OUTCOMES

Discharge Status

Discharge data were obtained from IDPH's CDR. There are 112 client discharge records for the 131 clients in this sample as of January 31, 2016. Of the 112 discharged clients, two-thirds (70 clients, 62.5%) successfully completed treatment, 22 (19.6%) were terminated, and 20 (17.9%) were neutrally discharged.

Length of stay in treatment ranged from zero to 449 days with a median length of stay of 129.5 days for those adolescents who were discharged. Table 11 shows discharge status.

Table 11. Treatment Completion Status

Discharge Status	N=112	Percent
Success	70	62.5%
Treatment Plan Completed	51	45.5%
Treatment Plan Substantially Completed	19	17.0%
Terminated	22	19.6%
Program Decision Due to Lack of Progress/Compliance	3	2.7%
Client Left	19	17.0%
Neutral	20	17.9%
Referred Outside	12	10.7%
Incarcerated	2	1.8%
Other	6	5.4%



Family Participation

In Year One, a tracking form was created for Focus Centers to track the total number of sessions attended by each adolescent, including sessions attended by family members. Focus Centers submitted this form to the evaluator within seven days of discharge. As of January 31, 2016, the evaluator had received family participation forms for 99 adolescents discharged from the project. These forms provided all of the required information, including the number of sessions per individual and family member. Table 12 shows the number of MDFT sessions attended by adolescents. The total number of sessions per adolescent ranged from 1 to 80, with a median of 16 sessions. Table 13 presents the number of adolescents who had a family member attend one or more sessions.

Table 12. Client Total Number of MDFT Sessions

Number of Sessions	Adolescents Discharged % (N=99)
One to Five	14.1 (14)
Six to Ten	17.2 (17)
Eleven to Fifteen	14.1 (14)
Sixteen to Twenty	18.2 (18)
Twenty-One to Twenty-Five	11.1 (11)
Twenty-Six to Thirty	12.1 (12)
Thirty-One to Thirty-Five	9.1 (9)
Thirty-six or More	4.0 (4)

NOTE: Percentages may not add up to exactly 100% due to rounding.

Table 13. Number of Adolescents with Family Member Attending Sessions

Family Member	(N=99)*
Parent	90
Grandparent	3
Brother/Sister	4
Other Relative	1

Note: The column total is not equal to the number of family members since multiple family members can attend one or more sessions.

Global Outcome Measures

Focus Centers and Year Two treatment providers implemented the Family Global Outcome Measure and the Adolescent Global Outcome Measure in February 2015. The agency therapist or therapist assistant administered this measure to clients and family members via the telephone approximately six months after discharge from the grant. Staff had two weeks before the six month post-discharge date and 28 days after that date to complete these Global Outcome Measures. The Global Outcome Measures ask both the adolescent and family member to indicate if they believe the adolescent improved, is the same, or worse regarding the adolescent's in general, their family interactions, substance use, mental health, and peer relations.

Since implementation, 34 Adolescent Global Outcome Measures were completed and 35 Family Global Outcome Measures were completed. Forms were not completed for several reasons, including: staff unable to reach clients or family members, staff unable to locate clients or family members, no forwarding address or phone number, and clients or family members declining to answer the questions. Both Global Outcome Measures (adolescent and family member) were completed for 32 clients. More specifically, there were two adolescents who completed the instrument, but there was not a corresponding a Family Global Outcome measure administered. Furthermore, three Family Global Outcomes Measures were completed with family members, however, the corresponding clients did not complete the Adolescent Global Outcome Measure. Hence, there are only 32 pairs of adolescent and family Global Outcome measures, and these 32 pairs are used in the Global Measure Agreement section below. In Figures 2 through 4 below, all available data are reported, which created different sample sizes.

Figure 2 shows that most adolescents reported improved or the same outcomes six months post-discharge, with one adolescent reporting that his/her substance use was worse.

Figure 2. Adolescent Global Outcome Measure

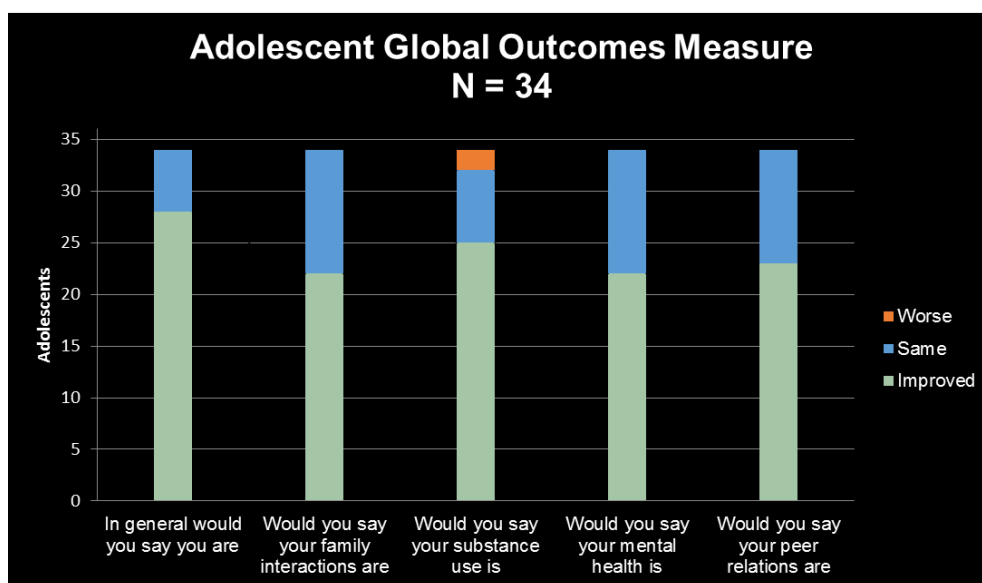


Figure 3 shows that family members reported that their adolescent improved, stayed the same, and was worse at six months post-discharge. One family member reported that the adolescent

was generally worse off; two reported that the adolescent's substance use was worse, and one reported that the adolescent's mental health was worse.

Figure 3. Family Member Global Outcomes Measure

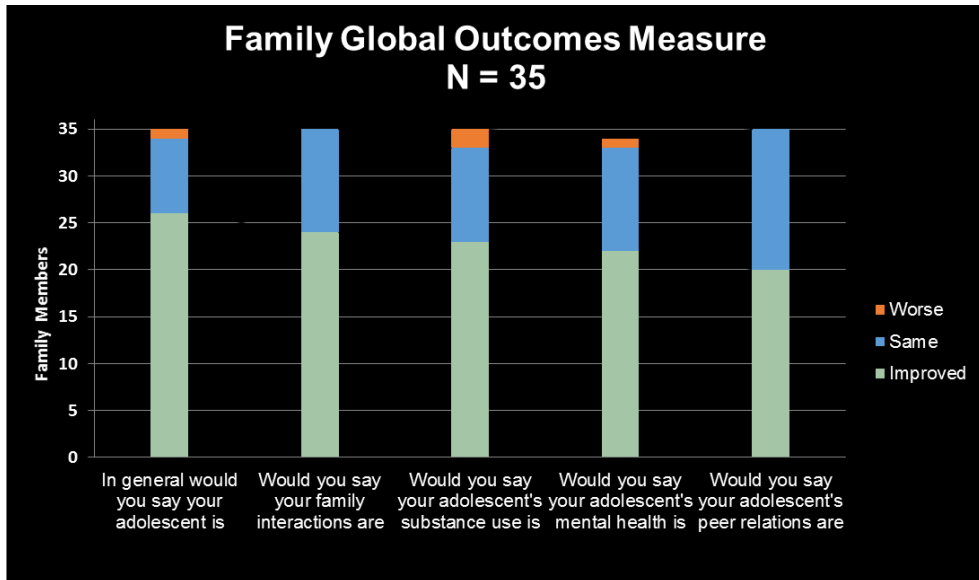
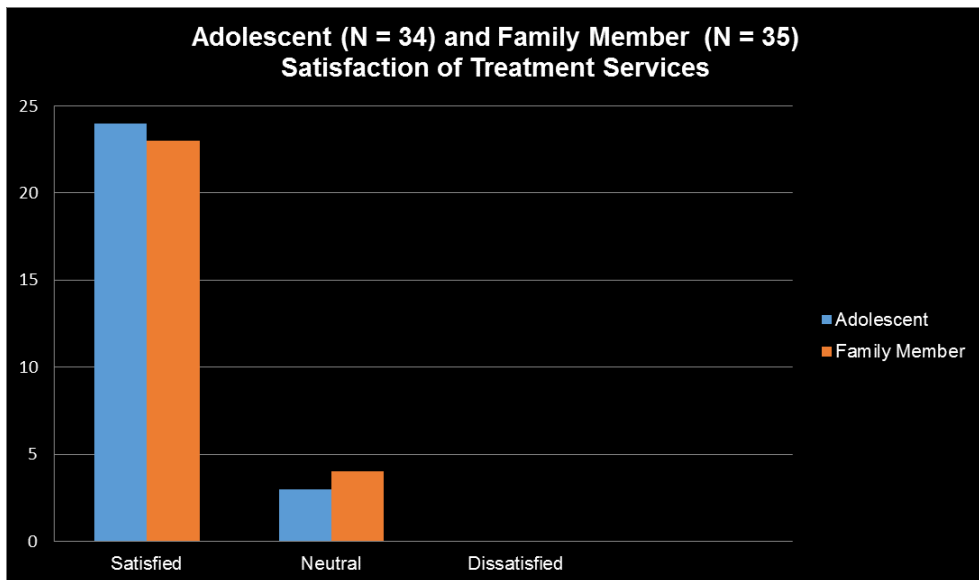


Figure 4 reports the adolescent's and their family member's level of satisfaction (ranging from satisfied, neutral, to dissatisfied) with the treatment services provided. Of the 34 adolescents who completed the Global Outcomes Measure, seven did not answer the satisfaction question, and of 35 family members who completed Global Outcome Measure, eight did not respond to the question on satisfaction. The majority of adolescents (24) and family members (23) reported were satisfied with treatment services. No one responded as being dissatisfied.

Figure 4. Adolescent and Family Member Satisfaction: Global Outcomes Measure



Note: The client satisfaction responses do not add up to the total of Adolescent and Family Global Outcome forms due to missing data.



Global Outcomes Measure Agreement

Analyses were conducted to determine if the Adolescent and Family Global Outcome Measures that were completed both by the adolescent and a family member showed agreement between the adolescent and the family member on the behavior of the adolescent at the time the measure was administered compared to the month before they started the MDFT program. For the six questions that were analyzed, respondents could respond improved, same (no change), or worse. The last question asked about satisfaction with the services received, which respondents could choose satisfied, neutral, or dissatisfied.

There was high agreement on one question, substantial agreement on two questions, moderate agreement on two questions, and fair agreement on one question. These analyses suggest that the adolescent and family are relatively consistent in their assessment of improvement from before to after the MDFT program.

Compared to the month before you or your adolescent entered the MDFT program:

In general, would you say you or your adolescent is: The adolescent and family member agreed in 31 of 32 client pairs (96.9%). Of those, 26/32 agreed that there was improvement and 5/32 agreed that there was no change. This demonstrates high agreement when we accounted for chance (Kappa = 0.89, .95% CI = .68, 1.00).

Would you say your family interactions are: The adolescent and family member agreed in 26 of 32 client pairs (81.3%). Of those, 18/32 agreed that it improved and 8/32 agreed that there was no change. This demonstrates a moderate agreement when we accounted for chance (Kappa = 0.59, .95% CI = .29, .88).

Would you say you or your adolescent's substance use is: The adolescent and family member agreed in 27 of 32 client pairs (84.4%). Of those, 21/32 agreed that the adolescent's substance use improved, 6/32 agreed that there was no change, and 0/21 agreed that the substance use was worse. This demonstrates a substantial agreement when we accounted for chance (Kappa = 0.63, .95% CI = .30, .89).

Would you say you or your adolescent's mental health is: The adolescent and family member agreed in 24 of 31 client pairs (77.4%). Of those, 17/31 agreed that the adolescent's mental health improved and 7/31 agreed that there was no change. This demonstrates a moderate agreement when we accounted for chance (Kappa = 0.50, .95% CI = .19, .82). One of the participant pairs did not answer this question.

Would you say you or your adolescent's peer relations are: The adolescent and family member agreed in 22 of 32 client pairs (68.8%). Of those, 15/32 agreed that the adolescent's peer relations improved and 7/32 agreed that there was no change. This demonstrates fair agreement when we accounted for chance (Kappa = 0.34, .95% CI = .004, .67).

How satisfied are you with the services you or the adolescent received: The adolescent and family member agreed in 23 of 24 client pairs (95.8%). Of those, 21/24 agreed that they were satisfied and 2/24 agreed that they were neutral. This demonstrates substantial agreement when we accounted for chance (Kappa = 0.78, .95% CI = .36, 1.00).



APPENDIX: KEY INFORMANT INTERVIEWS

Year One Key Informant Interviews

An evaluator from the Consortium visited the two sites approximately six months after sites began providing Focus services. Qualitative data were collected by completing key informant interviews with therapists assigned to the project.

Key informant interviews were conducted in-person on August 19 and 26, 2013. Interviews were conducted with all six designated Families in Focus (Focus) project treatment providers. Interview participants were provided the list of questions prior to their scheduled appointment and were given a minimum of one week to prepare. Interviews lasted between 40 and 70 minutes. Participation was voluntary with no anticipated risks associated with interview completion. Responses were kept confidential using the following methods: 1) data collected from the interviews is reported in aggregate form, without any identifying information; 2) notes were kept in a locked file cabinet in a locked office until this report was finalized, then all written notes were destroyed; and 3) electronic reports were maintained on a secure database and all individual responses were destroyed once this report was finalized. Interview participants were cooperative and provided constructive feedback regarding the project. Respondents were allowed to provide multiple responses to questions, so the numbers referenced below will not always add up to the total number of respondents. Responses to each question were synthesized and are provided below.

1. What affect do you think the Focus project has had on your agency? On your service area?

- Most respondents shared how they thought this project has affected their service area. These respondents all felt that the project has benefitted their service area. Three respondents noted that MDFT has filled a gap in the treatment spectrum between outpatient and residential therapies. One respondent stated, “Our service area now has a wider variety of available high-quality services. Another respondent discussed how juvenile court officers have really embraced MDFT and have been referring many clients for inclusion in this project.
- All respondents provided at least one comment about how this project has affected their agency, with most comments being positive. Four respondents noted that MDFT, especially the training component, really strengthened the therapeutic team’s skillset, confidence, and communication. Two respondents reported that the initial timing was challenging, as existing therapists had to discharge or transfer their cases before they could really get into MDFT, and then they only had one case per therapist while completing the training. Two respondents who were excited about implementing MDFT mentioned that they were already concerned whether MDFT could be sustained after this project ends.

2. Has the Focus project changed how you provide treatment services in your service area?

- Most respondents stated that the Focus project has changed how they provide treatment services, with the remainder noting that it is too early in the project to tell. Three respondents shared that MDFT training and implementation is very intensive, much more so than any other treatment modality. These respondents went on to note that their work is much more deliberate now, but that all the extra planning and



reviews mean they see fewer clients than if they were not implementing MDFT. Two respondents shared that with the inclusion of recovery supports and MDFT, their agency now provides complete wrap-around services for clients.

3. What do you think of Multi-Dimensional Family Therapy (MDFT)?

- All respondents reported that they thought MDFT was a very good treatment process, although several had some reservations too. Several respondents stated that the inclusion of family members really seemed to ensure that changes would be more lasting. Two respondents noted that the MDFT model serves the client and family well by not just focusing on mental health issues or substance abuse treatment, but by combining both along with recovery supports.
- Most respondents provided at least one reservation they felt about MDFT. Half of the respondents expressed concern about how MDFT could be sustained once this project ends. They felt that MDFT requires a lot of time that may not be billable, and weren't sure how even the recovery supports could be sustained once grant funds are expended. A couple respondents stated that MDFT seems to require a closer relationship than other modalities require, with evening meetings and constant contact via text.

4. What do you think of the Comprehensive Adolescent Severity Inventory (CASI)?

- Five respondents stated that the CASI is comprehensive and collects a lot of information, but that it takes too long to complete. Two of these respondents went on to share that they were told it would get easier with practice, but with how MDFT dictates a small caseload, they wouldn't get enough practice to improve their CASI collection process. One respondent wondered if there was a short CASI that could be administered to parents to, "see what their perspectives are and to better assess the family dynamic."
- Five respondents noted disappointment with the online version of the CASI. Some of these respondents talked about the technical problems the online system had at first and intermittent problems since. Three respondents requested that the online system be modified so that comments be entered and included in the report with specific questions, rather than running all the comments together for an entire section as the system currently does.

5. Have any of your clients provided feedback on MDFT or CASI? If yes, what did they think?

- All respondents shared feedback they heard from clients about either the CASI or MDFT, with several providing feedback about both. Five respondents reported that clients provided positive feedback about MDFT. Two specifically cited that clients talked about the availability of recovery supports as a valuable resource while the others reported that at least one of their clients talked about how family-focused therapy is.
- All respondents shared feedback from their clients about the CASI. Most of this feedback centered on how long it took to complete the CASI, with clients getting frustrated at how long it was taking. Alternately, one respondent shared that a client really liked how in-depth the CASI went, as it gave the adolescent a chance to really tell his or her life story.



6. Has MDFT enhanced your ability to provide therapy? How so or how not?

- All respondents stated that MDFT had enhanced their ability to provide therapy and strengthened them as therapists. Three respondents specifically noted the MDFT training as beneficial as it challenged them and required them to see the whole family as the client, and to treat the whole being and not just for substance abuse or mental health. Three respondents reported that MDFT requires much more planning and supervision than any other treatment modality they had ever used. Overall, they felt this improved the level of services they provided to their clients.

7. Do you think MDFT has increased family participation in treatment?

- All respondents stated that MDFT has increased family participation in treatment. Several respondents noted that family involvement is necessary to implement MDFT.
- One respondent reported that the utilization of so many different recovery supports sets MDFT up to benefit the entire family.

8. How well do you think the Focus project addresses your clients' cultural needs?

- All respondents stated that the Focus project seems to address their clients' cultural needs. Two respondents shared that MDFT specifically works with families of any culture. Two respondents added that this project is very supportive of rural families and families living in poverty because the recovery supports provide transportation supports to help them attend therapy sessions and other meetings necessary for success.

9. What has been the biggest success?

- Two respondents stated that the biggest success was having three therapists trained to implement an evidence-based treatment program that served families. Two respondents shared that adolescents and their families who had participated in MDFT were telling others in the community about their positive experiences. One respondent reported that the implementation of MDFT is going well and has already proven to be effective with the families who are participating. One respondent shared that MDFT has closed a gap in treatment services between outpatient and residential.

The biggest barrier?

- Four of the respondents stated that the biggest barrier has been timing so far during the project. Of these respondents, most felt like it took longer to get the project started than had been planned for. One respondent added that transitioning cases to other therapists so new MDFT cases could be added was a barrier.
- Several other responses were provided by single respondents. These included: 1) MDFT has not worked as well as planned in rural settings due to the number of meetings needed per week; 2) It is harder to set clear boundaries with clients as part of MDFT than other treatment modalities I've implemented; 3) A language barrier seems to exist across systems of this project. MDFT has specific language that doesn't always align with what is used by IDPH, insurance providers, or our agency. One example is how client is defined across these systems; and 4) I think that MDFT includes recreational-type activities with the adolescents. I don't think funds were built into the grant to support these relationship-building activities.



10. What do you think will be your biggest challenge associated with this project over the next six months?

- Three respondents identified the selection and introduction of two cohort agencies as the biggest challenge for the next half year. Three other respondents stated that beginning plans to sustain MDFT would be the biggest challenge of the next six months. One respondent added that maintaining a personal life while implementing MDFT on evenings and weekends would be another challenge.

11. What technical assistance topic areas would you like to see addressed?

- All respondents provided at least one suggestion for future technical assistance, with most providing more than one. Five respondents requested that the CASI online tool be fully tested and functional with all the kinks worked out in the near future. Two respondents asked for work to be done to define recovery supports to include funding levels. Two respondents identified a need for follow-up MDFT training, with one mentioning that this could be in tandem with training for the second cohort. Two respondents requested that more networking be encouraged across agencies, and asked if supervision feedback from the MDFT trainers could be shared with all Focus Centers. One respondent stated that the monthly check-in calls were useful and requested that they be continued. Ensure the CASI online tool is fully tested and works.

12. What ideas do you have for helping new agencies implement this project?

- Four respondents stated that they felt new agencies and their staff needed to be given more information and clear expectations from the beginning. One of these respondents added that the new agencies should be able to learn from the experiences of the first project year. Two respondents mentioned that improved communication and more collaboration would be needed as the new agencies begin. Other responses to this question included: 1) The first cohort agencies should show the new agencies how they manage their records; 2) implement a better training schedule, with therapists giving up their other cases earlier; 3) clearly define the role of recovery coaches; and 4) make sure they budget for the added costs associated with supervision and the MDFT training.



Year Two Key Informant Interviews

In Year 1, an evaluator from the Consortium visited the two Focus Centers in August 2013, a summary report was provided to IDPH. In Year 2, the evaluator conducted key informant interviews via the phone with all four sites. Qualitative data were collected by completing key informant interviews with 21 project staff, including 15 MDFT certified therapists, two MDFT project therapist assistants, and four MDFT treatment agency Directors and/or clinical Directors. A summary of Year 2 interviews are below.

Key informant interviews were conducted by phone during August 2014. Interview participants were provided the list of questions prior to their scheduled appointment and were given a minimum of one week to prepare. Interviews lasted between 30 and 60 minutes. Participation was voluntary with no anticipated risks associated with interview completion. Responses were kept confidential using the following methods: 1) data collected from the interviews is reported in aggregate form without any identifying information and 2) electronic reports were maintained on a secure database and all individual responses were destroyed once this report was finalized. Interview participants were cooperative and provided constructive feedback regarding the project. Respondents were allowed to provide multiple responses to questions, therefore the numbers will not always add up to the total number of respondents. Responses to each question were synthesized and are provided below.

1. What effect do you think the Focus Project has had on your agency and on your service area?

- All respondents shared how they thought this project has affected their service area. All respondents felt the project has benefitted their service area. Fourteen of 15 therapists stated the project has had a positive effect on their agency and/or their services area. More than half reported their agency has made changes that are in line with the MDFT model. Six of 15 stated their agency has a more focused approach as a result of the project.
- Two participants reported the Families in Focus project has not expanded past their county and has not affected other service areas. One stated they have expanded to surrounding counties. Four respondents stated that agency wide they have increased their focus and commitment to family. One therapist stated we were “looking for a better way to deliver services and MDFT was the answer”.
- Directors from all sites reported that the amount of training or supervision and additional time that the MDFT model required put a strain on the agency and other staff at the initial onset of the project.

2. Has the Families in Focus Project changed how you provide treatment services in your service area?

- Fourteen respondents stated that the Families in Focus project has had a positive change in how they provide treatment services. One therapist reported MDFT “has not changed how I provide services at this time”. Three reported an increase in clinical skills and family-based work.
- Three stated the supervision has made them a better quality clinician. Ten reported a change by involving families in treatment and shifted off individual focused treatment.



3. What do you think of Multi-Dimensional Family Therapy (MDFT)?

- All respondents reported that they thought MDFT was a very good treatment model. Over half reported they “love”, “enjoy”, or “like” the MDFT model. Two therapists stated they use the model on non-MDFT clients. One stated this model would be a good fit for new clinicians.
- All respondents commented on the high volume of time involved with training, supervision, and paperwork the model requires. Four reported the amount of paperwork is unreasonable. Three stated the training and supervision is a “little heavy”.
- All four agency Directors like the idea of a family based model and agreed that it would be helpful and effective. One Director expressed concern about reimbursement for the time outside of sessions working with the families. Two Directors stated that the MDFT program is successfully being launched with other treatment services.

4. What do you think of the Comprehensive Adolescent Severity Inventory (CASI)?

- Four CASI certified staff reported that the CASI is “not helpful or a “waste of time”. Three stated the CASI is time consuming and at times needs to be completed over two sessions. Three stated the instrument is very thorough and useful. Two stated the CASI is long, but valuable. One therapist stated the CASI is lacking in the substance abuse section.
- Treatment agency Directors’ responses were all different. One stated it was lengthy and difficult. One stated they like CASI’s structure, comprehensiveness, and narrative sections. One Director stated they were not sure the value that it brings to the agency. One Director stated it was time consuming.

5. Have any of your clients provided feedback on MDFT or CASI? If yes, what did they think?

- All respondents shared feedback they heard from clients about either the CASI or MDFT, with several providing feedback about both. All respondents reported that clients provided general positive feedback about MDFT. Two specifically stated that families liked an option besides residential treatment. One specifically stated a family liked the wrap-around services. Five reported that their families felt more connected.
- All respondents shared feedback from their clients about the CASI. Most of this feedback centered on how long it took to complete the CASI, with clients getting frustrated at how long it took.

6. Has MDFT enhanced your ability to provide therapy? How so or how not?

- All respondents stated that MDFT had enhanced their ability to provide therapy and strengthened them as therapists. Four respondents specifically noted increased confidence in working with families and felt more prepared. Three stated that their sessions are more structured and focused. Overall, they felt this improved the level of services they provide to their clients.



- All treatment agency Directors stated that their clinicians had in some way improved their clinical skills.

7. Do you think MDFT has increased family participation in treatment?

- All respondents stated that MDFT has increased family participation in treatment. Several respondents noted that family involvement is necessary to implement MDFT. One respondent reported that, “more families are involved with MDFT than those in just family therapy”. Three MDFT therapists stated it is not difficult to get “family buy-in”.
- All treatment agency Directors stated that MDFT has increased family participation with their MDFT clients. Two agencies stated they have increased their family participation throughout their agency.

8. How well do you think the Families in Focus Project addresses your clients’ cultural needs?

- All respondents stated that the Families in Focus Project is able to address their clients’ cultural needs. Two respondents shared that MDFT works with families of any culture. Two respondents added that this project is supportive of rural families and families living in poverty because the recovery supports component provides transportation assistance to help them attend therapy sessions and other meetings necessary for success. Five stated that the MDFT model is accommodating to cultural needs.

9. What has been the biggest success?

- Two respondents stated the number of certified MDFT therapists at their agency was a big success. Eight reported the biggest personal success was improvement in their clinical skills. Three stated seeing improved family function was a big success. One stated having an alternative to residential treatment was a success. All respondents reported multiple successes.

What has been the biggest barrier?

- Three of the respondents stated that getting the program started and implemented was a barrier. Over half of the respondents stated the amount of time in training was a barrier. All MDFT therapists reported obtaining reimbursement for all MDFT activities as a barrier.
- All treatment agency Directors stated integrating MDFT into the agency’s structure and shifting of staff workload was a barrier. Directors reported reimbursement of all MDFT services as a big barrier.

10. What do you think will be your biggest challenge associated with this project over the next six months?

- Most respondents stated that plans to sustain MDFT would be the biggest challenge of the next six months. Two respondents stated that completing training would be their biggest challenge. One respondent reported working with MDFT and MDFT clients would be a challenge over the next six months. Two respondents stated managing caseloads and documentation. One respondent reported having consistent referrals effected caseload quotas.



- Directors reported exploring and getting sustainable funding as the biggest challenge in the next six months.

11. What technical assistance topic areas would you like to see addressed?

- Not all respondents provided a suggestion for future technical assistance; however, most provided more than one. One respondent requested additional education in criminal behavior and court systems. Two respondents requested more networking be encouraged across agencies, and asked if supervision feedback from the MDFT trainers could be shared with all Focus Centers. One respondent stated that the monthly check-in calls were useful and requested that they be continued. One respondent requested a statewide networking group to share successful interventions. One requested additional education on age appropriate interventions. Two respondents stated no more training were needed.

12. What ideas do you have for helping new agencies implement this project?

- Eight respondents stated having prior knowledge and clearer expectations of time commitment and staff effort would be helpful. Three respondents identified having a manual with detail on program implementation is needed. Two respondents stated having agencies that already use or value family therapy would be helpful.



Year Three Key Informant Interviews

Each year, an evaluator from the Consortium conducts key informant interviews with Focus Center and Treatment Provider staff. In Year Three, qualitative data were collected by completing key informant interviews via the phone with four project therapists and four Directors or Clinical Directors from all four sites. A summary of Year Three interviews are below.

Interviews were conducted by phone during August 2015. Interview participants were selected at random and provided a list of questions prior to their scheduled appointment and were given a minimum of one week to prepare. Interviews lasted less than 30 minutes. Participation was voluntary with no anticipated risks associated with interview completion. Responses were kept confidential using the following methods: 1) data collected from the interviews is reported in aggregate form, without any identifying information, and any quotes are disguised to make the responder unidentifiable; 2) notes are kept in a locked file cabinet in a locked office until the report is finalized, then all written notes will be destroyed.

Respondents were allowed to provide multiple responses to questions, therefore the numbers will not always add up to the total number of respondents. Responses to each question were summarized and are provided below.

1. What effect do you think the Focus Project has had on your agency? On Your service area?

- All respondents thought that the project had a positive effect on their agency in some way and felt that the project had changed the way they deliver therapy. Staff from each agency mentioned that including the entire family system in therapy made all of the difference. Two respondents thought that the project increased the competency and confidence of clinicians.
- Five respondents thought that the project helped them work better with community partners. Staff from two agencies thought that it helped them work better with the Juvenile Court System and probation officers. It was emphasized that the Juvenile Court System and probation officers were very excited about the program because it offered a better treatment program for their clients; they appreciated the increased level of intensity for outpatient services.
- Directors from two sites reported that the project had changed the way they do clinical supervision. One Director reported that because of MDFT all supervision has been changed to video. One Director reported that their agencies successful completion rate of treatment tripled with MDFT.

2. Has the Focus project changed how you provide treatment services in your service area?

- Seven of eight respondents said that the project has changed how they provided treatment services in their area. They liked that it took the focus from the individual to the family system and establishing more comfort working with families has had a big effect.
- One therapist felt that if the model could have been incorporated into other services it would have had a bigger impact on the service area. One therapist reported that because of MDFT, the benefits of other evidence-based models are clear, and that MDFT was a catalyst for change in their entire organization.



- One staff member thought that it allowed them to plan therapy more effectively and focus more closely on the services they offer.

3. What do you think of Multi-Dimensional Family Therapy (MDFT)?

- All respondents believe that this is a good model with a comprehensive clinical approach. Over half reported that they “liked” the model or thought that it was “great”, “comprehensive”, or “structured”. Four respondents liked that it is inclusive and focuses on the entire family system.
- Three staff members thought that the required paperwork was nearly impossible to manage, that it was cumbersome and more labor intensive than what was necessary.
- Two staff members reported on the continued issues of sustainability without grant support. They worry that they are putting in a lot of time and effort that is not self-sustaining when the funding ends.

4. What do you think of the Comprehensive Adolescent Severity Inventory (CASI)?

- Six of eight respondents reported that they either liked the CASI or thought that it was an excellent tool and they enjoyed it. They thought it provided a comprehensive thorough assessment of the adolescent, they liked that it is a standardized structured model to collect information, and they felt the information that it collects is valuable.
- Two staff members reported that it takes too long to administer and must be done in multiple sessions. Over half reported that the actual time it takes to train on the CASI and then administer it was very time intensive. One agency thought that it interrupted the process of developing a therapeutic relationship with the adolescent due to the length.
- One respondent did not think the CASI was a very thorough assessment because it could only be done by people who have been trained in it. Another respondent thought that it was often difficult to know which adolescents to use it with.

5. Have any of your clients provided feedback on the MDFT or CASI? If yes, what did they think?

- Seven of eight respondents reported that clients had given them positive feedback on MDFT. It was reported that families really seemed to appreciate the emphasis on family therapy and they liked being included in the process. Families felt like there was better communication and that there would be a more successful outcome due to using MDFT.
- One therapist reported that while the families appreciated MDFT, some adolescents did not like it because the program took too long to complete.
- Seven out of eight staff members said they had not really received any feedback on the CASI. One respondent reported that some of the adolescents commented on the length of time it took to complete the CASI.



6. Has MDFT enhanced your ability to provide therapy? How so or how not?

- All respondents reported that MDFT has enhanced their ability to provide therapy. Half reported that it has increased the competency and confidence of therapists in the agency. One respondent thought that the amount of supervision required was often times burdensome.
- One therapist thought that MDFT really enhanced their ability to provide therapy because of the case management approach. They thought that it forced them and challenged them to look at adolescent development, family roles, family communication and interaction, and other systems in the adolescent's life.
- Three agency Directors reported that the skills they have learned from MDFT have carried over into other services. One Director reported that the training, intensity, oversight, and testing has helped them view things in a different but good way.

7. Do you think MDFT has increased family participation in treatment?

- All respondents reported that MDFT had increased family participation in treatment. One thought that because many families are referred to them by a probation officer, having the encouragement from their probation officer increased their involvement.
- One therapist pointed out that if the protocol is followed, there is no way it won't increase family participation, but the agency still had to work hard to get family participation.
- One staff member assumed most families would participate, however, not every family wanted to participate. Many families wanted the adolescent to figure it out themselves.

8. How well do you think the focus project addresses your clients' cultural needs?

- Six respondents reported that the project had in some way addressed their clients' cultural needs. Three staff members reported that being able to see the home environment, develop a relationship with the family, and see what kind of culture they come from was helpful because it allowed them to ask the family what cultural needs they had.
- One staff member thought that the recovery support services that were offered were a big part of addressing those cultural needs. Two therapists thought that being able to go out into the community (like schools) helped them understand the adolescent's environment better in addition to fostering relationships with the community that the adolescents lived in.
- One therapist reported that because this model involved the family, clinicians were able to overcome some language barriers with the adolescents with the family's help. Another respondent reported that language barriers were an issue that this model could not overcome. In one case, without the knowledge of available cultural resources that staff members had in relation to a family they were working with, they wouldn't have known where to get cultural support for this family from MDFT alone.



9. What has been the biggest success? The biggest barrier?

- Respondents from all agencies reported on the successes that they had, with several different success stories. Two respondents reported they had seen an increase in the successful completion rate of adolescent treatment and that MDFT helped them to define what a successful discharge meant for long-term success.
- Two staff members reported that the increased capability of their clinicians has been the biggest success. The preparation that the therapists had to put into MDFT has made them much better at what they do. One Director thought the biggest success was changing the culture of the organization to recognize that when evidence-based practices are appropriately matched to families, there are better outcomes and a higher likelihood for success.
- One respondent was grateful for MDFT, believing that it improved therapists ability to case conceptualize, which had definite benefits for clients in the end. Another respondent thought that the biggest success was increased understanding that in order to make changes in systems, you have to get involved in the entire system that the adolescent is a part of.
- Respondents at each agency reported on a variety of barriers during this project. Two staff members thought that staff turnover and workforce competition was the biggest barrier. Three respondents thought the requirements for implementing an evidence-based program were difficult. They felt that the amount of time it takes for therapists to be trained and develop proficiency was difficult. Two respondents also reported that the biggest barrier was the amount of paper work that needed to be done.
- Directors from three agencies thought that the biggest barrier was sustainability. They had to constantly worry about increased rates from insurance companies and managed care companies. They also continually worried about maintaining fidelity in a program like MDFT without grant funding.

10. Is there anything else that would be helpful for the evaluation team to know?

- Over half reported on this question and each had a different response. One respondent thought that this model could be improved if there was a way to streamline paperwork within the MDFT portal. Another respondent emphasized how important it was to give an agency time to sustain a change when working with an intensive evidence-based program like MDFT. This respondent thought there needed to be a culture shift to make it work and that everyone in the organization must be on board.
- One therapist thought that the project was very confusing from the very beginning, feeling that the agency lacked the guidance that was necessary to successfully implement a project like this one. One Director reported being surprised at how far they had come. Given all of the obstacles and barriers they needed to overcome, he was happy with how high the client numbers were.
- One staff member thought that putting a lot of stock in evidence based programs could be a waste of time because of the cycles that these programs go through. This respondent discussed how these programs are pursued and then not used anymore



once new research is identified, or bits and pieces of different evidence based programs are combined.

11. What ideas do you have for helping new agencies implement this project?

- All respondents had constructive ideas about helping new agencies implement this project. Two respondents thought that having more contact and guidance with the mentoring agency from the beginning would have been helpful so that they could avoid and learn from the mistakes that those agencies experienced. They would have liked to have been able to sit down with those agencies and talk about the philosophy of the project and unify how and why to do things.
- Two staff members discussed how important it was to get Masters level clinicians into the agency who can address both substance use disorders and co-occurring disorders, but that this was difficult because clinicians do not get that kind of experience in school. When they do get the experience, they leave the agency after only a couple of years. Both staff members have been trying to make this transition to all Masters level clinicians but it has been a struggle.
- Over half of the respondents talked about the issue of funding for a program like MDFT. Respondents discussed how reimbursement has to align with the extra costs or it just won't work as the current system of reimbursement is not sustainable. They also thought that it was important to have the funding available to have extra trainings and communications to work with other therapists and MDFT providers. Overall, these respondents are concerned that without the support MDFT cannot be sustained long-term.
- One staff member reported that given that evidence-based programs are so intensive, you must have full buy in and commitment from the staff or they would not recommend it. One staff member reported that a high volume of adolescents is imperative to viability of the program, or at least being located in an area where there is access to adolescents.
- One respondent thought that it would be beneficial to have everybody on the same page prior to implementation (juvenile courts, Magellan, other referral sources), believing this would have made the implementation process much smoother.

