

Families in Focus



THE IOWA CONSORTIUM FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

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Families in Focus

Year One Annual Evaluation Report September 2013

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BACKGROUND

The Families in Focus (Focus) project began in Iowa upon receipt of grant funding through the State Adolescent Treatment, Enhancement, and Dissemination (SAT-ED) project from the Substance Abuse and Mental Health Services Administration (SAMHSA). This project began in October, 2012 with the appointment of the Project Director within the Iowa Department of Public Health (IDPH). The two initial treatment providers are Youth and Shelter Services (YSS) in Ames and Prairie Ridge Addiction Treatment Services (PRATS) in Mason City. The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducts the evaluation for the Focus project.

The purpose of the Focus project is to expand and enhance the states' adolescent treatment services. To this end, providers are implementing Multi-Dimensional Family Therapy (MDFT), an evidence-based program. Prior to involvement in MDFT, provider staff will administer the Comprehensive Adolescent Severity Inventory (CASI) to potential clients. This assessment identifies whether the client and family are suitable for MDFT. Each provider has designated two therapists, one treatment supervisor, and a treatment assistant to the project, along with support from other staff as warranted by the clients' treatment plans or grant management needs.

Implementation

Immediately upon grant award notification, staff at IDPH and the treatment providers began developing the implementation process. This largely centered on identification of key staff, scheduling trainings and conference calls, and working out contractual issues. Implementation could not begin until necessary staff had been trained, but once the initial MDFT training was held, therapists immediately began working with their initial supervision cases. Once therapists were certified, they took on more cases and by the end of this reporting period, therapists and therapist supervisors were seeing clients as planned.

TRAINING

MDFT

An MDFT initial training was held January 14-17, 2013 at YSS. Three therapists from each treatment provider attended the full training; while other treatment provider staff, state representatives, and evaluation team members attended part of the training. After the initial training, therapists had homework to complete and began implementing MDFT with one trial case. These trial cases were recorded and reviewed by the MDFT trainer. In addition,



therapists had weekly conference calls with the MDFT trainers to review cases and assist with case planning.

A follow-up MDFT training was held at each agency during June 2013 to complete the training process. During these follow-up site visits from MDFT trainers, therapists participated in two days of case review and consultation and live supervision. Live supervision sessions consisted of one hour prep and planning for the session, the family therapy session and a half hour post session debriefing. During each therapy session, the two other agency therapists and trainers would watch the session live. If necessary, MDFT trainers would communicate directly to the therapist in session to provide guidance or direction. This was an intense learning experience and opportunity to receive onsite training. This process was followed for each therapist, allowing for all to have similar hands-on learning and an opportunity for professional and clinical growth.

The therapist training process was completed by the end of this reporting period, with all therapists being certified to provide MDFT. At this point, the therapists took on additional cases as planned.

On June 28, 2013, the MDFT trainer began training one treatment supervisor from each agency to become an MDFT supervisor. These supervisors will undergo a process similar to that for regular certification, with regular contact with the trainer and review of techniques. This process was ongoing at the end of this reporting period and will continue for at least the next six months.

CASI

The initial CASI training was held February 7-8, 2013 at PRATS. This training was attended by the project therapists from each treatment provider, as well as state and evaluation representatives. In addition, other therapists from YSS attended the training as YSS intends to use CASI throughout their service area and not just for this project. CASI training was held via webinar on March 27, 2013 to introduce project members to the online version. Several e-mail discussions were held amongst project and agency staff to work out the details of using the on-line system and to ensure all data are recorded appropriately. An in-person follow-up CASI training was held on April 9, 2013 with all therapists certified to administer the CASI.

GPRA

The Project Director provided a Government Performance and Results Act (GPRA) training to the PRATS therapists on March 27, 2013. This training was an overview of the data entry process. A similar GPRA training was held with the YSS therapists during April 2013. Both agencies began entering GPRA data as required for this grant. A couple entries were made without an agency-specific code at the beginning of the Client ID code, but this issue has since been addressed. A total of 13 GPRA intake interviews have been entered into the online system.



Grant-Required Meetings

The Project Director and Evaluator participated in monthly check-in calls organized by the SAMHSA project team and attended by all SAT-ED awardees. In addition, the SAMHSA Project Officer assigned to Iowa led a couple of calls with the Project Director and Evaluator to discuss Iowa-specific progress, plans, and technical assistance needs.

Project representatives also attended the national grantee meeting March 12-14, 2013 in Rockville, MD. Five Iowa representatives attended this meeting and participated in several work plan development sessions and attended the presentations.

OUTCOMES

Overall numbers served to date are insufficient to report meaningful outcome data for the first project year. This is due to: 1) The intensity of MDFT cases; MDFT therapists carry a much smaller caseload than other therapists; and 2) Therapists only had one case during the training phase as that case was actively supervised and monitored by the MDFT trainer. The following general information is provided as an update, with more in-depth outcomes reporting to be included in future reports as the sample size increases.

MDFT

An MDFT Implementation Toolbox (Toolbox) was to be used to monitor MDFT implementation fidelity and key milestones. Unfortunately, the Toolbox was not available during the first project year. The MDFT developers are working on this system, and once it is made available, data from the Toolbox will be analyzed and included in future reports.

GPRA

From the beginning of the project through the end of August 2013, twenty-four intake GPRA were administered between YSS and PRATS. Four discharge GPRA were administered and three six-month follow-up GPRA were collected.

Public Presentations

The Focus project requires treatment providers to publicly promote all aspects of the project. To monitor this, the treatment assistant from each provider is compiling public presentations and submitting that information to the evaluator. During the first project year, only a handful of public



presentations were given as staff were learning about the various project parts. As staff become more comfortable and well-versed in using and discussing the CASI and MDFT, the number and frequency of public presentations will increase. Presentations given were about MDFT or the project in general, with the audience either being school or juvenile court personnel. Most presentations lasted less than thirty minutes, but two did last between 75 and 90 minutes. Most presentations were given to small groups ranging from three to ten people, with one person being the minimum audience size and twenty five being the maximum.

KEY STAFF 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. A summary of these interviews may be found beginning below through page 8.

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 really 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 really 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 more 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 two 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 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 are 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.

RECOMMENDATIONS FOR YEAR TWO

In the course of preparing this report and reviewing information obtained during key informant interviews, the following recommendations may be advisable:

- Continue the monthly check-in calls, and schedule specific calls with a smaller group as warranted (e.g. call with treatment assistants to discuss how they are tracking trainings and public presentations).



- Open trainings held for the cohort 2 agency staff to staff from PRATS and YSS. This would help PRATS and YSS further develop their MDFT and CASI- related skills, and would allow them to share their practical experiences with the new practitioners.
- Both MDFT and the CASI are more labor intensive than other treatment and assessment modalities, respectively. Changes will need to be made in how services are funded to fully sustain these services. These sustainability efforts will take time and should be a primary focus for the remainder of the project.
- Foster collaboration and communication between agencies. Their staff are the MDFT and CASI experts, any lessons learned or experiences they have will likely benefit all other MDFT and CASI practitioners.

