Families in Focus
Year Two Report

THE IOWA CONSORTIUM FOR SUBSTANCE ABUSE RESEARCH AND EVALUATION

Year Two
Annual Evaluation Report
Revised
December 2014

With Funds Provided By:
Prairie Ridge Addiction Treatment Services;
Youth and Shelter Services;
Iowa Department of Public Health,
Division of Behavioral Health;
Substance Abuse and Mental Health Services Administration

Year Two Annual Evaluation Report
Revised
December 2014

Amy Mason, LMSW
Evaluation Coordinator

Julie Palmer, BA
Associate Director

Stephan Arndt, PhD
Director

Suggested Citation:

Mason, A., Palmer, J., & Arndt, S. (2014) Families in Focus: Year Two Annual Evaluation Report. Iowa City, IA; The University of Iowa: Iowa Consortium for Substance Abuse Research and Evaluation.
http://iconsortium.subst-abuse.uiowa.edu/

EXECUTIVE SUMMARY

The Iowa Department of Public Health (IDPH) was awarded a 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 Families in Focus project. The goals of this grant include moving toward a more coordinated effort to serve adolescents and their families and to expand and enhance the states' 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 include development of Iowa's professional workforce by providing MDFT and CASI training to staff, as well as conducting a process and outcome evaluation.

The Families in Focus Project began in Iowa in October 2012 with two substance abuse treatment agencies: Prairie Ridge Addiction Treatment Services (PRATS) in Mason City and Youth and Shelter Services (YSS) in Ames. In Year 2, two additional treatment providers were added to the project: MECCA Services (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 Families in Focus Project. This report examines activities and outcomes from October 1, 2012 through August 30, 2014.

MDFT and CASI Training

As of August 30, 2014, there have been 16 therapists trained or working towards MDFT certification. One therapist left the project, leaving 15 currently active MDFT staff. Of the 15 staff members, eight therapists have either completed or are on track to complete MDFT supervision certification. One MDFT supervisor is currently on the MDFT trainer track, with anticipation of two more being added in Year 3. Moving into Year 3, the MDFT therapists and MDFT trainers will be preparing to sustain and further disseminate the model. The project is on target for achieving the sustainability objective to train a team of 18 certified MDFT therapists, six certified MDFT supervisors, and two statewide MDFT trainers. Ten staff from the four sites have been trained in the use of the CASI assessment. Therapists use this tool to screen if the client is appropriate for MDFT.

Participant Characteristics

Age and Sex: Adolescents in the Families in Focus project range from 14 to 18 years of age; the majority of participants are 16 or 17 years of age. Nearly 59% of the participants are male and 41.1% are female.

Race and Ethnicity: Nearly 70% of the adolescents participating in the project are white, five participants (8.9%) are African American, one adolescent (1.8%) is American Indian; data for race are missing for 11 participants (19.6%). The project has served one adolescent of Hispanic or Latino ethnicity.

Substance Use at Admission: Of adolescents reporting a primary substance, 40 participants (71.4%) indicated substance use in the 30 days prior to admission; two clients reported they did not know when asked how many days they had used alcohol or illegal drugs. Marijuana was the most common primary substance reported by 57.9% of the participants, followed by alcohol (40.4%).

Co-Occurring Disorders: Records indicate 45 of the 56 adolescents (80.4%) were screened for co-occurring disorders. Co-occurring disorders were identified for all 45 participants (100%). Although data indicates the remaining 11 adolescents were not screened, one treatment agency

reported to the evaluator that screening did occur, however data for the screening questions for these 11 participants were entered incorrectly.

Substance Use at Admission and Follow-Up

Follow-up interviews are conducted with participants approximately six months following admission to the Families in Focus project. Questions and responses refer to activity in the last 30 days: the admission period refers to the 30 days preceding the admission interview and the follow-up period refers to the 30 days preceding the follow-up interview. Of the 56 adolescents in the project, 36 participants have completed the follow-up interview. Seven of the 36 adolescents (19.4%) reported abstinence from alcohol and illegal drugs in the 30 days prior to admission. Twenty-five participants (69.4%) reported abstinence in the 30 days prior to the follow-up interview; one client declined to answer questions about substance use at the follow-up interview. For these 36 adolescents, marijuana was the most common substance of use at admission with 22 adolescents (61.1%) reporting use in the past 30 days. Fifteen adolescents (41.7%) reported the use of alcohol in the 30 days preceding admission. At follow-up, nine adolescents (25%) reported marijuana use and four participants (11.1%) reported use of alcohol in the 30 days preceding the interview. Alcohol use (exact McNemar Test, $p < 0.004$) and illegal drug use (exact McNemar Test, $p < 0.005$) showed statistically significant reductions from admission to follow-up.

Past 30 Day Alcohol and Illegal Drug Use at Admission and Follow-Up

	Admission % (N=36)	Follow-Up % (N=36)
No Use of Alcohol or Illegal Drugs	19.4 (7)	69.4 (25)
Alcohol	41.7 (15)	11.1 (4)
Marijuana/Hashish	61.1 (22)	25.0 (9)
Heroin	2.8 (1)	2.8 (1)
Hallucinogens/Psychedelics	2.8 (1)	2.8 (1)
Methamphetamines	2.8 (1)	2.8 (1)
Inhalants	2.8 (1)	0.0 (0)
Other Illegal Drugs	0.0 (0)	2.8 (1)
Declined to Answer Questions	0.0 (0)	2.8 (1)
Five or More Drinks in One Sitting	13.9 (5)	2.8 (1)
Use of Illegal Drugs	63.9 (23)	25.0 (9)
Used Alcohol and Drugs on the Same Day	13.9 (5)	0.0 (0)
Injected Drugs in Past 30 Days	2.8 (1)	2.8 (1)

Note: Column totals are not equal to the number of individuals since adolescents report all substances used in the past 30 days.

Rural Youth Participation

Data on rural admissions were collected through IDPH's Central Data Repository. Focus Center staff furnish the evaluator with CDR identification numbers through a tracking form. While the numbers are small, there is a statistically significant trend for increasing rural admissions over the period (Jonckheere-Terpstra Test, exact $p < 0.04$).

TABLE OF CONTENTS

BACKGROUND

The Iowa Department of Public Health (IDPH) was awarded a 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 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 Families in Focus Project began in Iowa in October 2012 with two substance abuse treatment agencies: Prairie Ridge Addiction Treatment Services (PRATS) in Mason City and Youth and Shelter Services (YSS) in Ames; the first year sites are referred to as the Focus Centers. In Year 2, two additional treatment providers were added to the project: MECCA Services (MECCA) in Iowa City and Heartland Family Services (HFS) in Council Bluffs; the second year sites are referred to as treatment providers. The Iowa Consortium for Substance Abuse Research and Evaluation (Consortium) conducts the evaluation for the Families in Focus Project.

The four sites are implementing Multi-Dimensional Family Therapy (MDFT), an evidence-based practice. Prior to involvement in MDFT, Focus Center staff administer the Comprehensive Adolescent Severity Indicator (CASI) to potential project participants. This evidence-based assessment tool identifies whether the adolescent and family are suitable for MDFT. This report examines activities and outcomes from October 1, 2012 through August 30, 2014.

DATA COLLECTION AND MANAGEMENT SYSTEMS

Data Collection

Focus Center staff collect Government Performance and Results Act (GPRA) data for adolescents at admission, discharge, and 6-month post-admission (follow-up). In addition to GPRA data, the Consortium also utilizes treatment admission data collected for participants from IDPH's Central Data Repository (CDR). At discharge, family participation forms are transmitted to the Consortium indicating the number of MDFT sessions each adolescent attends, including attendance by family members. In Year 3, the Consortium is working with IDPH to develop Adolescent and Family Global Outcome Measures. These data will be included in subsequent reports.

MDFT Clinical Management System

The MDFT originators developed a web-based clinical management system (MDFT Clinical Portal) that serves several functions for this project. This system offers a method of communication for therapists, supervisors, and trainers, including transmission of rating sheets,

recorded clinical sessions, and ratings on clinical outcomes. The system became available during Year 2. Sites are considering entering prior project participant cases into the system.

The system also offers three standard reports:

- Appendix A on page 22 shows the MDFT Training Program Report, a fidelity system document that displays averages of various therapist activities by Focus Center.
- Appendix B on page 23 presents the Clinical Outcome Behavioral Report used to display clinical outcomes for closed cases by showing status of behavioral outcomes at treatment discharge.
- Appendix C on page 24 shows the Clinical Outcome Improvement Report, which provides the percentage improvement from admission to discharge for MDFT participants.

STAFF

Each Focus Center initially designated 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 1, 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. Implementation began with the initial training of staff in the MDFT model and the CASI. Select Focus Center staff have been trained simultaneously to be MDFT supervisors. Training efforts continued in Year 2 with the addition of the two treatment providers. Implementation efforts in Year 2 focused on workforce expansion and sustainability by adding additional trained staff for MDFT at the two additional treatment provider sites.

MDFT and CASI Training

Multi-Dimensional Family Therapy is the evidence-based practice chosen by the State of Iowa to help expand and enhance the states' adolescent treatment services. Training includes therapists completing homework and implementing MDFT with one trial case. Training cases are recorded and reviewed by the MDFT trainer. In addition, initially therapists had weekly conference calls with the MDFT trainers to review cases and assist with case planning.

Follow-up MDFT trainings were held at each treatment agency to complete the training process. During 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.

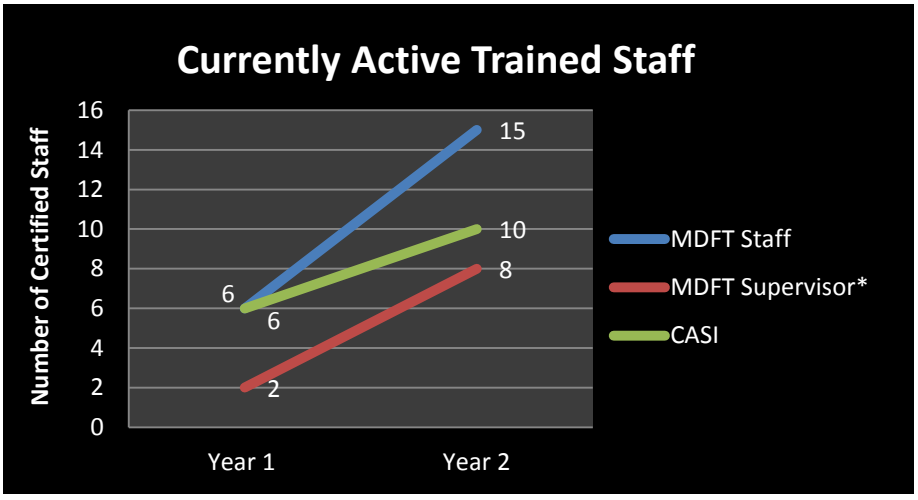
In Year 1, MDFT training began for one treatment supervisor from each Focus Center to become an MDFT supervisor. These supervisors underwent a process similar to that for regular certification, with regular contact with the trainer and review of techniques. This process continued for a minimum of six months. At the beginning of Year 2, the trained MDFT supervisor left YSS. The remaining MDFT trained supervisor at PRATS was able to provide supervision for the other agencies that were still in process of completing MDFT certification.

As of August 30, 2014, 16 therapists have been trained or are working towards MDFT certification. One therapist left the project, leaving 15 currently active MDFT staff. Of the 15 staff members, eight therapists either completed or will complete MDFT supervision certification. One MDFT supervisor is currently on the MDFT Trainer track, with anticipation of two more being added in Year 3. Moving into Year 3, the MDFT therapists and MDFT trainers will be preparing to sustain and further disseminate the model. The project is on target for achieving the sustainability objective to train a team of 18 certified MDFT therapists, six certified MDFT supervisors, and two statewide MDFT trainers.

Ten staff from the four sites have been trained in the use of the CASI assessment. 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 with clients that are not in the Families in Focus Project.

Figure 1 shows the number of currently active CASI and MDFT trained staff working with the Families in Focus project. Of the 15 MDFT certified therapists, three (20%) are male and 12 (80%) are female. The majority of MDFT therapists (93.3%) are white and one (6.7%) is African American.

Figure 1: Number of Currently Active CASI Certified and MDFT Trained Staff in the Families in Focus Project by Year



Note: Staff can be trained in more than one category, therefore totals do not equal the total number of staff involved with the project.
*This includes staff who have completed and who are on track to complete MDFT supervision certification.

GPRA Training and Records

The IDPH Project Director provided GPRA training to the PRATS therapists in March 2013. This training provided an overview of the data collection and entry process. A similar GPRA training was held with YSS therapists in April 2013. Staff from both Focus Centers enter GPRA data as required for this grant. Entries made in Year 1 that omitted an agency-specific code in the client identification code.

As shown in Table 1, 56 GPRA admission interviews, 30 discharge records, and 36 completed follow-up interviews were entered as of August 30, 2014. Data from one duplicate admission record are excluded in the report. In the process of analyzing data for this report, there is the potential there are additional GPRA identification code errors which have not been corrected that may lead to duplicate clients in the admission, discharge, and follow-up datasets. Consequently, data in future reports may change if treatment agency staff resolve the potential errors.

Table 1: Number of GRPA Records Completed by Project Year

Year	Admission	Discharge	Follow-Up
Year 1	27	13	11
Year 2	29	17	25
Total	56	30	36

MDFT Participants

Description of Participants at Admission

Tables 2 and 3 present sex and age at admission. Of the 56 adolescents, 33 (58.9%) are male and 23 (41.1%) are female. Adolescents range from 14 to 18 years of age, the majority of participants are 16 or 17 years of age.

Table 2: Adolescent's Sex at Admission

Gender	All Adolescents % (N=56)
Male	58.9 (33)
Female	41.1 (23)

Table 3: Adolescent's Age at Admission

Years of Age	All Adolescents % (N=56)
14	14.3 (8)
15	16.1 (9)
16	32.1 (18)
17	35.7 (20)
18	1.8 (1)

Table 4 presents race and ethnicity reported at admission. The majority of adolescents (69.6%) are white, five participants (8.9%) are African American, and one adolescent (1.8%) is American Indian; data for race are missing for 11 adolescents (19.6%). The project has served one adolescent of Hispanic or Latino ethnicity.

Table 4: Adolescent's Race and Ethnicity

Race	All Adolescents % (N=56)
White	69.6 (39)
African American	8.9 (5)
American Indian	1.8 (1)
Data Missing for Race	19.6 (11)
Ethnicity	
Hispanic/Latino	1.8 (1)

Table 5 presents results from screening for co-occurring mental health and substance use disorders at admission. Of the 56 adolescents admitted to the project, 45 records indicated participants were screened for co-occurring disorders and all 45 adolescents screened positive. Although data indicates screening for co-occurring disorders had not occurred for the remaining 11 adolescents, one Focus Center reported to the evaluator screening had occurred, however data for the screening questions for these 11 participants were entered incorrectly.

Table 5: Screening Results for Co-Occurring Disorders

Co-Occurring Disorder Screening	All Adolescents % (N=56)
Positive Screen	80.4 (45)
Not Screened*	19.6 (11)

*GPRA data indicate 11 adolescents from one site were not screened, however staff later clarified that screenings were conducted and data were entered incorrectly.

Substance Use at Admission

GPRA data contain questions regarding alcohol and drug use in the 30 days before admission to the Families in Focus project. All GPRA data are self-reported by adolescents. As shown in Table 6 on the following page, use of illegal drugs was reported more frequently than alcohol use. Marijuana was the most common substance at admission with 32 adolescents (57.1%) reporting use in the past 30 days. Twenty-two participants (39.3%) reported the use of alcohol in the past 30 days. Two of the adolescents (3.6%) reported methamphetamine use. Fourteen adolescents (25%) reported no use of alcohol or drugs within the last 30 days.

Table 6: Substance Use Reported at Admission

Substance Use in Past 30 Days	All Adolescents % (N=56)
Used Only Alcohol	12.5 (7)
Used Only Illegal Drugs	32.1 (18)
Used Alcohol and Illegal Drugs	26.8 (15)
No Use of Alcohol or Illegal Drugs	25.0 (14)
Reported "Don't Know" for Either Alcohol or Illegal Drug Use	3.6 (2)
Alcohol	39.3 (22)
Any Illegal Drug Use	58.9 (33)
Marijuana/Hashish	57.1 (32)
Methamphetamine	3.6 (2)
Heroin	1.8 (1)
Hallucinogens/Psychedelics	1.8 (1)
Inhalants	1.8 (1)
Other Illegal Drugs	1.8 (1)

Note: Column totals are not equal to the number of individuals since adolescents report all substances used in the past 30 days.

Consuming five or more drinks in one sitting and drinking alcohol on the same day as using drugs were relatively infrequent compared to drug use as indicated in Table 7.

Table 7: Binge Drinking, Same Day Alcohol and Drug Use, Injection Drug Use

Alcohol and Drugs	All Adolescents % (N=56)
Five or More Drinks in One Sitting	14.3 (8)
Used Alcohol and Drugs on the Same Day	12.5 (7)
Injected Drugs in Past 30 Days	1.6 (1)

Note: Column totals are not equal to the number of individuals.

Family and Living Conditions

Tables 8 through 20 on the following pages provide additional information for the 56 adolescents for select GPRA questions. The following are common characteristics of the adolescents in the MDFT project:

- Over 76% reported living in someone else's apartment, room, or house.
- Over three-quarters (76.8%) of the adolescents indicated experiencing stress in the 30 days prior to admission due to their use of alcohol or drugs.

- 92.9% of the participants reported being enrolled in school or a job training program.
- Nearly 40% were employed part-time.
- Eight adolescents (14.3%) reported being arrested in the past 30 days with five participants indicating the arrests were drug- related offenses.
- Nearly 60% reported being on parole or probation.
- Over one-third of the participants (35.7%) reported experiencing anxiety in the past 30 days and 30.4% reported experiencing serious depression.
- Nearly all adolescents (96.4%) indicated they have interaction with family or friends who are supportive of their recovery.

Table 8: Housing

Housing Situation	All Adolescents % (N=56)
Shelter	3.6 (2)
Institution	8.9 (5)
Own/Rent Apartment, Room, House	8.9 (5)
Someone Else's Apartment, Room, House	76.8 (43)
Residential Treatment	1.8 (1)

Table 9: Substance Use Causing Stress, Reduction in Activities, and Emotional Problems

Stress, Activities, Emotional Problems Due to Alcohol and Drug Use	All Adolescents % (N=56)
Experienced Stress Due to Use of Alcohol or Other Drugs in Past 30 Days	76.8 (43)
Use of Alcohol or Other Drugs Caused Reduction or Giving Up Important Activities in Past 30 Days	66.1 (37)
Use of Alcohol or Other Drugs Caused Emotional Problems in Past 30 Days	73.2 (41)

Note: Data in the table above reflect individuals who answered the questions; there are missing data for one client for each question.

Education and Employment

As shown in Tables 10 through 12 on the following page, the highest level of education completed by the adolescents ranged from 7th grade to 12th grade, with a median of 10th grade; 35% of the participants reported completing 10th grade. Twenty-two of the 56 adolescents, (39.3%) reported currently being employed part-time with 20 adolescents (35.7%) reported they were unemployed and not looking for work. Nearly all adolescents (92.9%) are enrolled in school or a job training program.

Table 10: Highest Level of Education Completed

Highest Level of Education Completed	All Adoles6ents % (N=56)
7th Grade	3.6 (2)
8th Grade	12.5 (7)
9th Grade	19.6 (11)
10th Grade	35.7 (20)
11th Grade	26.8 (15)
12th Grade	1.8 (1)

Table 11: Employment

Employment	All Adolescents % (N=56)
Employed Part-Time (<35 hrs/wk)	39.3 (22)
Unemployed, Looking for Work	23.2 (13)
Unemployed, Not Looking for Work	35.7 (20)
Other	1.8 (1)

Table 12: Adolescents Reporting Enrollment in School or Job Training Programs

School Enrollment or Job Training Program	All Adolescents % (N=56)
Currently Enrolled in School or Job Training Program	92.9 (52)

Note: Column totals are not equal to the number of individuals.

Crime and Criminal Justice

Over 85% (48 adolescents) reported no arrests in the 30 days before admission while 14.3% (eight adolescents) reported one or more arrests. Of those arrested, no adolescent reported more than two arrests and five participants indicated the arrest was drug-related. Over 62% reported committing a crime in the 30 days prior to admission; 57.1% were on parole or probation.

Table 13: Client Reports of Arrests and Criminal Justice Involvement

Arrested in Past 30 Days	All Adolescents % (N=56)
No	85.7 (48)
Yes	14.3 (8)
Drug-Related Arrest(s)	**Adolescents Arrested % (N=8)**
No	37.5 (3)
Yes	62.5 (5)
Committed Crime in Past 30 Days	**All Adolescents % (N=56)**
No	37.5 (21)
Yes	62.5 (35)
Parole or Probation	**All Adolescents % (N=56)**
No	42.9 (24)
Yes	57.1 (32)

Mental and Physical Health Problems and Treatment and Recovery

Tables 14 through 20 on the following pages provide information for the 56 adolescents for select GPRA questions related to physical and mental health services and issues. The following are common characteristics of the adolescents in the MDFT program:

- Over 70% of the adolescents reported their overall health as "good" at the time of admission.
- Eleven adolescents (19.6%) reported having received inpatient treatment services for alcohol or substance abuse in the past 30 days.
- Less than 33% reported receiving outpatient treatment services for alcohol or substance abuse in the past 30 days.
- Less than 6% reported any type of emergency room services in the past 30 days.
- Seventeen adolescents (30.4%) reported experiencing serious depression and 20 adolescents (35.7%) reported experience serious anxiety or tension.
- Of the 56 adolescents, over 25% reported experiencing violence or trauma during their lifetime.
- One adolescent reported having been hit, kicked, slapped or otherwise physically hurt in the past 30 days.

Table 14: Overall Health

Self-Rating of Overall Health	All Adolescents % (N=56)
Excellent	5.4 (3)
Very Good	8.9 (5)
Good	71.4 (40)
Fair	12.5 (7)

Table 15: Adolescents Reporting Inpatient Treatment

Receiving Inpatient Treatment In Past 30 Days	All Adolescents % (N=56)
Physical Complaint	0.0 (0)
Mental or Emotional Difficulties	5.4 (3)
Alcohol or Substance Abuse	19.6 (11)

Note: Column totals are not equal to the number of individuals.

Table 16: Adolescents Reporting Outpatient Treatment

Receiving Outpatient Treatment In Past 30 Days	All Adolescents % (N=56)
Physical Complaint	0.0 (0)
Mental or Emotional Difficulties	3.6 (2)
Alcohol or Substance Abuse	32.1 (18)

Note: Column totals are not equal to the number of individuals.

Table 17: Adolescents Reporting Emergency Room Visits

Receiving Emergency Room Treatment In Past 30 Days	All Adolescents % (N=56)
Physical Complaint	3.6 (2)
Mental or Emotional Difficulties	3.6 (2)
Alcohol or Substance Abuse	5.4 (3)

Note: Column totals are not equal to the number of individuals.

Table 18: Mental Health

Mental Health Issues Experienced In Past 30 Days	All Adolescents % (N=56)
Serious Depression	30.4 (17)
Anxiety or Tension	35.7 (20)
Hallucinations	7.1 (4)
Trouble Understanding, Concentrating, or Remembering	16.1 (9)
Trouble Controlling Violent Behavior	21.4 (12)
Attempted Suicide	5.4 (3)
Prescribed Medication for Psychological/Emotional Problems	16.1 (9)

Note: Data in the table above reflect adolescents who answered the questions. The number of participants who declined to answer questions and the number of individuals who responded they did not know the answer varied for each question.
Column totals are not equal to the number of individuals.

Table 19: Violence and Trauma

Experienced Violence or Trauma in Lifetime	All Adolescents % (N=56)
Yes	26.8 (15)
No	73.2 (41)

Table 20: Physical Injury

Physically Hurt in Past 30 Days	All Adolescents % (N=56)
Yes	1.8 (1)
No	98.2 (55)

Social Connectedness

Fewer than 8% (4 adolescents) reported attending some type of voluntary group in the 30 days prior to admission. Nearly all adolescents (98.2%) reported having someone to turn to when having trouble; 96.4% reported having interactions with family or friends who support their recovery.

Table 21: Social Connectedness

Social Connectedness	All Adolescents % (N=56)
Attended Any Type of Self-Help Recovery Groups including Religious/Faith-Based, Non-Religious, or any Other in Past 30 Days	7.1 (4)
Interaction With Family/Friends Who Support Recovery	96.4 (54)
Have Someone to Turn to When Having Trouble	98.2 (55)

Note: Column totals are not equal to the number of individuals.

CHANGES FROM ADMISSION TO FOLLOW-UP

Of the 56 adolescents, 36 have completed the GPRA follow-up interview approximately six months following their admission to the Families in Focus project. GPRA questions and responses refer to activity in the last 30 days: the admission period refers to the 30 days preceding the admission interview and the follow-up period refers to the 30 days preceding the follow-up interview. Table 22 provides self-reported data at admission and follow-up for alcohol and illegal drug use for the 36 adolescents completing the follow-up interview. Seven of the 36 adolescents (19.4%) reported abstinence from alcohol and illegal drugs in the 30 days prior to admission. Twenty-five participants (69.4%) reported abstinence in the 30 days prior to the follow-up interview; one client refused to answer questions about substance use at the follow-up interview. Marijuana was the most common substance of use at admission with 22 adolescents (61.1%) reporting use in the past 30 days. Fifteen adolescents (41.7%) reported the use of alcohol in the 30 days preceding admission. At follow-up, nine adolescents (25%) reported marijuana use and four participants (11.1%) reported use of alcohol in the 30 days preceding the interview. Alcohol use (exact McNemar Test, $p < 0.004$) and illegal drug use (exact McNemar Test, $p < 0.005$) showed statistically significant reductions from admission to follow-up.

Table 22: Alcohol and Illegal Drug Use at Admission and Follow-Up

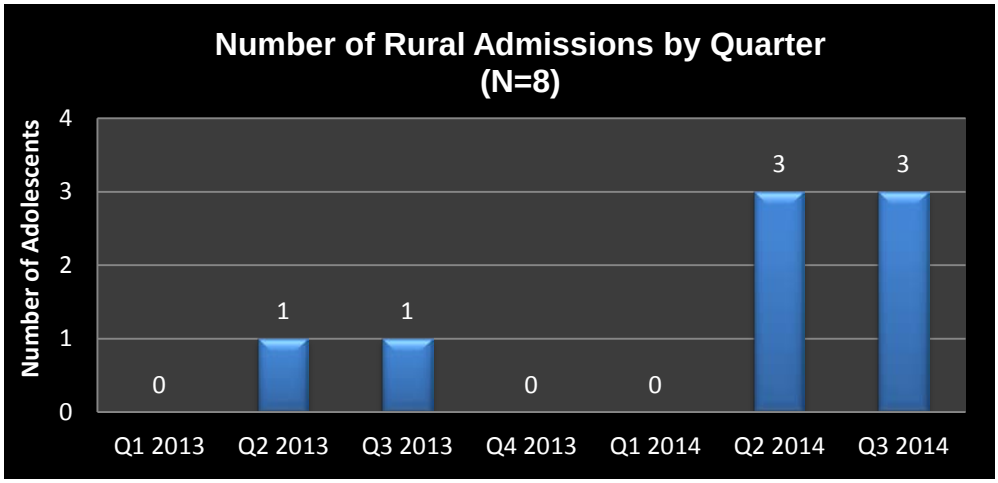
Past 30 Day Alcohol and Illegal Drug Use at Admission and Follow-Up		
	Admission % (N=36)	**Follow-Up % (N=36)**
No Use of Alcohol or Illegal Drugs	19.4 (7)	69.4 (25)
Alcohol	41.7 (15)	11.1 (4)
Marijuana/Hashish	61.1 (22)	25.0 (9)
Heroin	2.8 (1)	2.8 (1)
Hallucinogens/Psychedelics	2.8 (1)	2.8 (1)
Methamphetamines	2.8 (1)	2.8 (1)
Inhalants	2.8 (1)	0.0 (0)
Other Illegal Drugs	0.0 (0)	2.8 (1)
Declined to Answer Questions	0.0 (0)	2.8 (1)
Five or More Drinks in One Sitting	13.9 (5)	2.8 (1)
Use of Illegal Drugs	63.9 (23)	25.0 (9)
Used Alcohol and Drugs on the Same Day	13.9 (5)	0.0 (0)
Injected Drugs in Past 30 Days	2.8 (1)	2.8 (1)

Note: Column totals are not equal to the number of individuals since adolescents report all substances used in the past 30 days.

Rural Youth Participation

Data on rural admissions were obtained through the Central Data Repository. While the numbers are small, there is a statistically significant trend for increasing rural admissions over the period (Jonckheere-Terpstra Test for trend, exact $p < 0.04$).

Figure 2: Rural Admissions

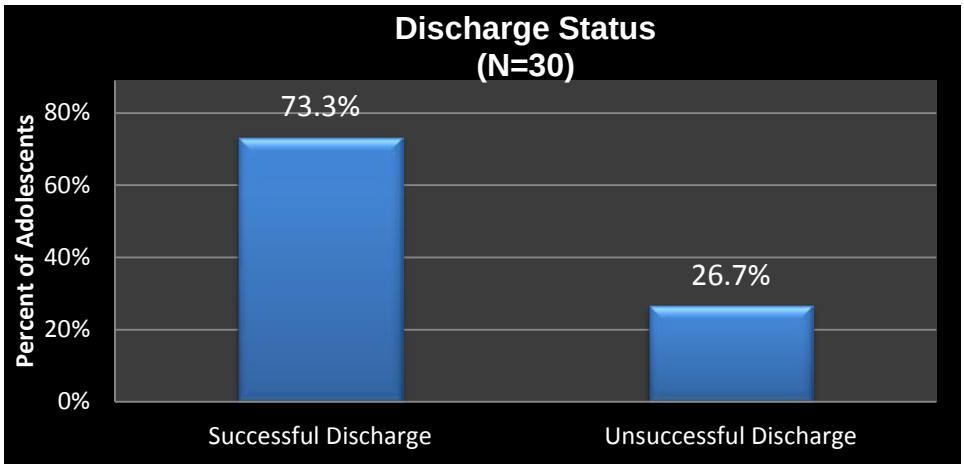


DISCHARGE AND TREATMENT SESSIONS

Discharge

Figure 3 shows the discharge status recorded in GPRA by Focus Center staff. Twenty-two of 30 participants (73.3%) successfully completed and graduated from MDFT treatment. Eight adolescents (26.7%) did not successfully complete the program.

Figure 3: Discharge Status



Family Participation

In Year 1, 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 submit this form to the evaluator at discharge. Table 23 shows the number of MDFT sessions attended by adolescents; Table 24 presents the number of adolescents who had a family member attend one or more sessions. As of August 30, 2014, the evaluator has received participation forms for the 30 adolescents discharged from the project. The total number of sessions per adolescent ranged from 4 to 40, with a median of 23 sessions.

Table 23: Adolescents' Total Number of MDFT Sessions

Number of Sessions	% (N=30)
One to Five	6.7 (2)
Six to Ten	10.0 (3)
Eleven to Fifteen	16.7 (5)
Sixteen to Twenty	6.7 (2)
Twenty-One to Twenty-Five	16.7 (5)
Twenty-Six to Thirty	20.0 (6)
Thirty-One to Thirty-Five	20.0 (6)
Thirty-Six to Forty	3.3 (1)

Table 24: Adolescents with Family Participation by Parent or Grandparent

Family Member	% (N=30)
Parent	96.7 (29)
Grandparent	3.3 (1)

KEY STAFF 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, including15 MDFT certified therapists, two MDFT project therapist assistants, and four MDFT treatment agency Directors and/or clinical Directors were interviewed. 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 specially 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. Once 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 are 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 trainings 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.

RECOMMENDATIONS FOR YEAR THREE

- Maintain monthly conference calls facilitated by the IDPH Project Director including the evaluator, Focus Center, and treatment provider staff. These calls are an important part of infrastructure, sustainability, reinforce data collection guidelines and expectations, and cover many other topics related to the project. Discontinuation of these regular calls created challenges for the staff at the Focus Centers, the treatment providers, and for the evaluator. Instituting regular calls is recommended.
- Continued training of other treatment providers in Iowa on the MDFT model. This would allow others to be introduced to the MDFT model and find future potential MDFT therapists. In addition, it would allow the MDFT treatment providers to share their practical experiences with the new practitioners.
- Explore ways to increase participants from rural and minority populations.
- Explore ways to increase MDFT project admissions to reach targeted GPRA intake numbers.
- Provide additional GPRA training to reduce occurrence of missing data.
- Explore how services can be 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.
- Develop a structured process for other substance abuse treatment agencies that want to implement MDFT in the future.

APPENDIX

Appendix A: MDFT Training Program Report

MDFT Training Program

Average Report

Reporting period: From: To:

Program name:

Agency name:

Date of report:

No.	Item	
1.	Site requirement score:	
2.	Number of supervisors:	% certified:
3.	Number of therapist:	% certified:
4.	Percent of sessions in clinic:	
5.	Average therapist caseload:	
6.	Average case duration:	
7.	Number of cases served:	
8.	Service capacity:	
9.	Utilization rate over report period:	
10.	Percent of case closed with failure to engage:	
11.	Percent of cases closed that completed at least 3 months of treatment:	

No.	Item
1.	Average travel time:
2.	Percent of sessions recorded (DVD):
3.	Average monthly therapist contact in minutes:
4.	Average monthly therapist family sessions contact in minutes:

No.	Item
1.	Average 3-month supervisor case review supervision sessions:
2.	Average 3-month supervisor DVD supervision sessions:
3.	Average 3-month supervisor live supervision sessions:
4.	Average 3-month team building activities:
5.	Average therapist evaluation:

Appendix B: Clinical Outcome Behavioral Report

MDFT Training Program

Clinical Outcome Behavioral Report

Reporting period: From: To:

Program name:

Agency name:

Date of report:

Closed Case Report Clinical Outcomes : Status of behavioral outcomes at treatment discharge

No.	Item
1.	Percent of youth living at home/not in placement:
2.	Percent of youth in school/working:
3.	Percent of youth with no new arrests:
4.	Percent of families with no new child abuse/neglect reports:
5.	Percent of youth with marijuana/alcohol use less than 10 days per month:
6.	Percent of youth with no hard drug use:
7.	Percent of youth who rarely or never engage in illegal activities other than drug/alcohol use, shoplifting, trespassing, loitering, truancy, etc.:
8.	Percent of youth who rarely or never engage in unprovoked violent behavior:
9.	Percent of youth with no, minor, and/or stable mental health functioning:
10.	Percent of youth who do not affiliate exclusively with anti-social peers and/or activities:
11.	Percent of youth not at high risk for STDs & pregnancy:
12.	Percent of families who are not characterized by poor family functioning:
13.	Percent of families who do not regularly resort to family violence:

No.	Item
1.	Percent of youth not on probation:
2.	Percent of youth with no open child welfare case:
3.	Percent of cases closed successfully:
4.	Extent to which youth on a safe and healthy trajectory:
5.	Reason for treatment discharge:
a.	Percentage met goals:
b.	Percentage placed in jj system:
c.	Percentage moved out of area/unable to locate:
d.	Percentage place in residential treatment:
e.	Percentage /family dropped out of treatment before goals were met:
f.	Percentage unknown:

Appendix C: Clinical Outcome Improvement Report

MDFT Training Program

Clinical Outcome Improvement Report

Reporting period: From: **To:**

Program name:

Agency name:

Date of report:

Closed Case Report Clinical Outcomes: Percent improvement from intake to discharge

No.	Item
1.	Marijuana and/or alcohol use:
2.	Hard drug use:
3.	Delinquency/Crime:
4.	Aggressive and violent behavior:
5.	Involvement in pro-social activities:
6.	School attendance:
7.	Mental health functioning:
8.	Family violence:
9.	Family functioning:
10.	Sexual health risk:
11.	School grades/performance:
12.	Peer affiliation: