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**An Evaluation of the
Marigold Program,
Umatilla County, Oregon**

A Byrne Grant

Year 2 Evaluation Report

Submitted to:

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Executive Summary

In October 2001, Homestead Youth and Family Services in Pendleton, Oregon, received funding from the Edward Byrne Memorial Formula Grant Program to establish a new in-home family therapy program for at-risk adolescent girls in Umatilla County. This grant award, administered through the Oregon Department of State Police Criminal Justice Services Division, provided Homestead with the funds necessary to launch the Marigold program, which uses Functional Family Therapy (FFT) to address the needs of Umatilla County's at-risk youth and their families.

The Year 2 Evaluation Report highlights several program successes, including:

- Increased referrals and increased number of referring agencies;
- Increased referrals from schools;
- Rapid scheduling of intake appointments;
- Staff competency; and
- Providing a necessary service to an underserved population.

During Marigold's second year of operation, the number of referrals to Marigold more than doubled, increasing from 40 in Year 1 to 97 in Year 2, and the number of service providers referring to Marigold also increased. Schools were the single largest referral source during Year 2. Marigold's referral process is easy and highly accessible. The short length of time between the referral and the intake session (nearly 1/3 of intake sessions happen on the same day as the referral) shows Marigold's proficiency in receiving and processing referrals. However, there was evidence that some community partners were uncomfortable with making Native American referrals to Marigold.

Marigold staff continued to gain skill with the FFT model during Year 2. FFT has chosen to train the program director as a national FFT consultant, which reflects Marigold's high degree of adherence to, and proficiency with, the FFT model. Counselor case notes ratings indicate that counselors felt they made good progress on a number of goals with the families they have served. Program staff members also have successfully integrated case management services into the final phase of the FFT model.

Based on demographics, assessment scores and presenting issues of the families served by Marigold, the program is reaching its target population. The 30 youth served in Year 2 were within eligibility age range and the majority of youth served were girls. Marigold has begun serving a small number of at-risk boys and their families. Youth exhibited multiple risk factors including substance use, criminal involvement, and problems with individual and family functioning. Assessment data indicate that youth and their parents showed some positive changes over the course of therapy. Change scores between the entry and exit assessment scores for youth and their parents indicate some improvement in individual and family functioning.

The report also provides the following recommendations for Year 3:

- Public relations efforts should describe the FFT model and philosophy, the type and extent of family change that is realistic to expect, and what types of families are appropriate for FFT services. Marigold also should consider some innovative public relations materials, such as short educational videos.

- Marigold staff should clarify with referring agencies the extent of information they can provide about the families receiving services at Marigold, and may wish to create a short, standardized family update form for referring agencies that would be completed by the counselors.
- Marigold staff should begin open communication with one or two representatives of the Native American community in order to determine what would make Native American service providers comfortable with making referrals to Marigold.
- Marigold should modify its data management procedures in order to capture data not available in the new Web-based CSS, to keep more complete documentation on those families who do *not* enroll in services, and to maximize the number of matching entry and exit assessments for each family.

Chapter 6 of the Year 2 Evaluation Report provides a discussion of the challenges faced by the Marigold program along with the rationale for each of the above recommendations.

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Chapter 1: Background and Program Description

Marigold Program Purpose and Goals

In October 2001, Homestead Youth and Family Services in Pendleton, Oregon received funding from the Edward Byrne Memorial Formula Grant Program to establish a new in-home family therapy program for at-risk adolescent girls in Umatilla County. This grant award, administered through the Oregon Department of State Police Criminal Justice Services Division, provided Homestead with the funds necessary to launch the Marigold program, which uses Functional Family Therapy (FFT) to address the needs of Umatilla County's at-risk youth and their families.

Several community partners assisted Homestead in planning the new program, including the Umatilla County Commission on Children and Families, the County Juvenile Services Division, Oregon Youth Authority, and Services to Children and Families. In addition, feedback was invited from school officials, the Public Health Department, and the Confederated Tribes of the Umatilla Indian Reservation. Homestead and its community partners decided that a family therapy service for girls was a natural choice for the focus of the new program for several reasons. First, services for girls were sorely lacking in Umatilla County despite the fact that arrests and incarcerations of teen girls have risen faster than rates for teen boys during the 1990s. Second, Umatilla County's 5-Year Comprehensive Strategy for Serious, Violent and Chronic Offenders identified family conflict and management as risk factors for violent behavior and stressed that these should be target areas for future services. Creating a FFT program for at-risk girls would meet the demand for gender-specific and family-focused services.

Homestead identified three main goals for the new program. First, the program would increase individuals' coping and life management skills, which in turn would strengthen and stabilize the family. Second, the program would help families identify strategies to increase parenting skills. Finally, the program would help families achieve effective communication and functioning. It was hoped that with improved family relations and communication, participating girls would reduce their delinquency behavior, substance abuse, and school truancy.

Marigold staff and community partners recognized during the first year of program operation that Umatilla County's boys and their families also could benefit from a FFT program. Therefore, when Homestead applied for continued Byrne Grant funding for a second year of operation, they specified that the program would begin serving a limited number of boys (no more than five boys and their families at any given time). Homestead hoped to retain Marigold's primary focus on serving girls, while at the same time provided a valuable service to boys and their families.

Functional Family Therapy

Functional Family Therapy was developed in 1969 by researchers at the University of Utah to treat families from a variety of cultures with myriad relational issues and presenting problems but who were typically labeled as difficult or resistant to treatment. FFT at its core is a strengths-based model: "FFT providers have learned that they must do more than simply stop bad behaviors: they must motivate families to change by uncovering family members' unique strengths, helping families build on these strengths in ways that enhance self-respect, and offering families specific ways to

improve¹.” FFT therapists help families focus on the multiple individual and relational systems in which the families live.

The FFT model consists of three phases: engagement and motivation, behavior change, and generalization. The focus of Phase 1, engagement and motivation, is to address any issues that might inhibit families’ full and productive engagement with therapy and to build on those individual and family strengths that will contribute to successful therapy. During this phase, therapists work to create a shared understanding of the presenting problems and build trust with the family members. During Phase 2, behavior change, the therapist works with the family to create and implement short and long-term behavior change plans tailored to each family member’s needs and perspective. It is in this phase that the therapist can address parenting skills, delinquency behavior, and communication skills, for example. In the final phase, generalization, the therapist helps the family apply positive behavior change techniques to additional situations and potential problems that could arise in the future.

Assessment is an integral component of FFT and occurs at program intake, throughout therapy, and at program exit. FFT requires the use of a series of assessment instruments that allow therapists to measure individual and family functioning, and changes in such functioning, over time. The model has been used for over 30 years in a variety of settings with at-risk and delinquent clients, and an extensive body of research has found the model to be a successful and cost-effective means for reducing recidivism.

Program Evaluation

The Criminal Justice Services Division has required all Byrne Grant awardees to take part in a series of evaluation activities. Each grantee was required to hire an external evaluator, create a Comprehensive Evaluation Plan, and complete several phases of evaluation activities. Phase 1, Building Evaluation Capacity, stipulates that the grantee must create a program description, logic model, and a comprehensive evaluation plan (CEP) that outlines the program’s goals and objectives along with plans for measurement, data collection, and analysis. Phase 2, Process Evaluation, requires evaluators to conduct a process evaluation to determine the population served, the quantity and quality of services, and barriers to program implementation. Phase 3, Outcome Monitoring, requires sites to measure changes in violence and crime-related behavior or correlates of violence and crime-related behavior among program participants. Phase 4, Outcome Evaluation, is required only of those grantees *not* implementing a “model program.” FFT qualifies as a model program, and therefore the Marigold program is not required to take part in an outcome evaluation involving control or comparison group samples.

In January 2002, Homestead contracted with NPC Research, Inc., a Portland-based research and evaluation firm, to serve as the external evaluator for the Marigold program. NPC Research is working with Homestead to ensure that the agency complies with each required evaluation phase. Evaluation activities in Year 1 included designing the process evaluation and outcome monitoring components of the evaluation, and conducting the first year of the process evaluation. In September 2002, NPC Research released the Year 1 Evaluation Report, covering activities between October 2001 and July 2002. This report summarized the process evaluation of the first year of the Marigold program including a description of the families served (demographics, assessment scores, and presenting issues), an analysis of the program staff’s use of the FFT model, and a summary of

¹ Thomas L. Sexton and James F. Alexander (2000). *Functional Family Therapy*, OJJDP Juvenile Justice Bulletin, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

challenges and successes during the first year of operation. NPC Research will produce annual reports documenting each subsequent year of the program's operation. Byrne Grant requirements state that each annual report should discuss activities during the fourth quarter of the previous year, and the first three quarters of the current year. Therefore, data in this report covers families served between July 1, 2002, and June 30, 2003. For the sake of brevity, we use the term "Year 2" throughout the report to refer to this time period.

During Year 2, evaluation activities included a continued process evaluation as well as outcome monitoring. Each of these components is described here.

Process Evaluation

The purpose of a process evaluation is to monitor program implementation. The process evaluation can provide the program with valuable information on the extent to which the project was implemented as planned or the extent to which adaptations to the plan were necessary. Furthermore, the study can offer the program feedback on challenges, successful strategies, and recommendations for future operations. The qualitative data gathered from a process study also can be used to explain and elaborate upon quantitative outcome data. Many questions can be answered by a process evaluation. Below is a list of questions addressed by the Marigold process evaluation:

- Is the program getting the number of referrals it expected? Why or why not?
- What are the characteristics of the youth and families referred to the program (including age, race, risk characteristics, and presenting family issues and needs)?
- Are clients' goals reached in the expected 12-week treatment time period? Why or why not?
- Is the program successfully adhering to the FFT model? Why or why not?
- What are the challenges to successfully implementing the FFT model in this community and with these clients?
- Are case management services utilized? What types of needs do families seeking case management have? Are there some needs that cannot be met in this community?
- What have been the most successful aspects of the program?
- What has presented the largest challenges?
- Are there any adjustments the program could make in order to improve the quality of services offered to families?

The Year 2 process study consisted of interviews with project staff and key stakeholders, a review of program output data, a review of client satisfaction data, and a review of therapist progress notes. Several groups of individuals served as key informant interviewees including all Marigold staff, a FFT consultant, and a group of community service providers and partners. NPC Research conducted telephone interviews with these 16 individuals from potential, and actual, referral agencies, including the juvenile department, mental health service providers, school counselors, representatives from the police department, workers from the Health Department and from Services for Families and Children (SCF), representatives from the Umatilla Tribe, and representatives from nonprofit social service agencies.

In addition to the qualitative data gathered through interviews, quantitative data provided valuable information for this evaluation. NPC analyzed demographic, risk factor, and service utilization data for the process study to determine whether the program is serving the target population. At program

intake, counselors collect a variety of demographic information such as age, race, school grade, and parents' education level and employment status. Counselors also record information about the client and family's alcohol and drug abuse history and involvement with the justice system. To measure level of risk, the program utilizes the Juvenile Crime Prevention (JCP) Risk Screen. This screen categorizes risk factors into five domains: school issues, peer relationships, behavior issues, family functioning, and substance abuse. Clients are rated as at risk in a domain if they exhibit at least one risk factor in that domain. Clients' total risk score also can be calculated by summing the number of risk factors across domains. While Marigold has used the JCP Risk Screen to determine program eligibility (youth must exhibit at least two risk factors to be eligible for services) since program inception, Marigold staff did not begin electronically recording JCP Risk Screen results for each client until December 2002. Thus, JCP Risk Screen scores are not reported here for clients entering service prior to that date.

Finally, each therapist completes a progress note at the close of every therapy session. These notes track the issues that were addressed in the therapy session; the challenges that arose; the current needs of the family; family goals and progress toward those goals; and plans for future therapy sessions. These forms contain a wealth of data, including therapists' perceptions of family progress and the use of FFT constructs and techniques. NPC analyzed these data to describe the utilization of FFT strategies and techniques and therapists' growth and proficiency with the model.

Outcome monitoring

During Year 2, outcome monitoring consisted of measuring families' scores on a series of required FFT instruments. All programs implementing the FFT model are required to use a series of standardized assessment tools to measure individual and family functioning at the start and at the completion of therapy. These tools include the Outcome Questionnaire (OQ45.2), the Family Assessment Measure (FAM), the Youth Outcome Questionnaire (YOQ), and the Problem Oriented Screening Instrument for Teenagers (POSIT). These tools are discussed in more detail in Chapter 3.

In addition to these instruments, FFT requires that all clients complete an additional instrument at the time of program exit, called the Client Outcome Measure (COM). This measure asks clients to report changes in family functioning (including conflict, communication, and parenting skills) since the start of therapy and also asks for information regarding criminal activity, school attendance, and substance abuse. In addition, therapists complete a similar measure for each family called the Therapist Outcome Measure (TOM).

Marigold staff administers the above assessments to all clients and their families and report the scores electronically in a customized FFT database. In the spring of 2003, FFT headquarters transitioned all FFT programs to a Web-based database in lieu of a customized Access database. These data are then transferred to NPC Research for analysis. NPC was able to analyze the intake data for all families served along with the exit data for the subset of families that completed therapy by June 30, 2003.

Year 2 Evaluation Report

The remainder of this report documents NPC's process evaluation of Marigold's second year of implementation along with outcome data on those families that have completed services. Where appropriate, in addition to reporting on those families served during Year 2 (as described above, we are using this term to refer to families served between July 1, 2002, and June 30, 2003), we report data for all families served since program inception. Chapter 2 outlines the referral process and referral sources. Chapter 3 describes the families served including demographics, assessment

scores, and presenting issues. Chapter 4 documents Marigold's services, including the program's utilization of, and adherence to, FFT, serving targeted populations, and case management. Chapter 5 discusses program retention and outcomes, including an analysis of families who drop out of the service treatment duration, and assessment change scores. The final chapter of the report, Chapter 6, summarizes the program's successes, challenges, and recommendations for Year 3.

Chapter 2: Referral Process

This chapter provides a description of the referral and eligibility process, including referral sources, the number of youth referred to Marigold, and the results of the JCP assessment tool used to determine eligibility for Marigold's services.

Referral Sources

As described in Chapter 1, NPC evaluators conducted interviews with representatives from community organizations including the juvenile department, Umatilla County schools, the police department, the Health Department, the Department of Health Services (DHS), Services for Families and Children (SCF), the Umatilla Tribe, the Oregon Youth Authority (OYA), Umatilla County Mental Health, and nonprofit social service agencies.

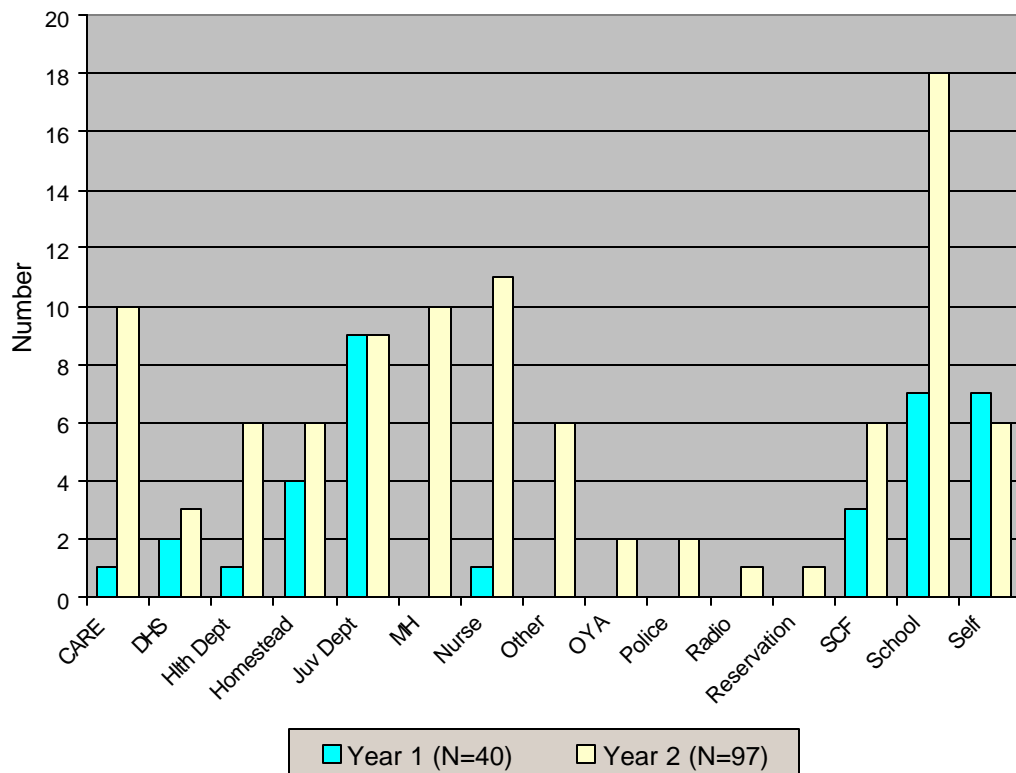
In these interviews, respondents indicated that they initially learned about Marigold's services in several ways. Some heard about Marigold informally from Homestead and Marigold staff, others attended a formal presentation or received brochures from Marigold, and several were told about the program by coworkers, colleagues, or supervisors.

All interview respondents believed that their agency staff members who refer to Marigold are very knowledgeable about the program. Two-thirds of those asked could accurately articulate Marigold's services. However, one respondent believed that Marigold was a schooling program for girls and another thought Marigold provided sex education services to youth. Both of these respondents had received initial information directly from Marigold staff either from a formal presentation or through program literature. Several respondents indicated that Marigold continues to give out updated flyers and actively spreads information about Marigold's services. Others indicated that they haven't received new information about Marigold since last year.

Marigold typically received between two and three referrals per week. In Year 2, Marigold received 97 referrals from more than 15 different sources. As Figure 1 illustrates, all referral agencies increased the quantity of their referrals from Year 1 to Year 2, except for the Juvenile Department, from which the number of referrals remained constant, and self-referrals, which decreased by one. In addition, several new sources began actively referring to Marigold, including Umatilla County Mental Health (MH), the Oregon Youth Authority (OYA), the Police Department, as well as "other" community agencies².

² Other community agencies included the Commission on Children and Families; Tanya House (a runaway shelter), Domestic Violence Services, and the Community Resource Team.

Figure 1. Referrals to Marigold in Year 1 and Year 2



More than half of the families referred by the Juvenile Department (72%, or 13 out of 18 youth), DHS (60%, or 3 out of 5 youth), the Health Department (57%, or 4 out of 7 youth), and self, family or friend referrals (57%, or 8 out of 13 youth) enrolled in Marigold’s services. About one-third of families referred by SCF (44%, or 4 out of 9 youth), Homestead (33%, or 4 out of 10 youth), school counselors (31%, or 8 out of 25 youth), and mental health providers (30%, or 3 out of 10 youth) enrolled in Marigold’s services; one-quarter of families referred by a nurse practitioner (25%, or 3 out of 12) and 17% (2 out of 11 youth) referred by CARE enrolled in Marigold’s services.

Referral Process

According to interview respondents, the referral process for Marigold services was “very smooth.” Families were referred to Marigold in two ways. First, the referrer would tell a family about Marigold or give the family a brochure. Then, the referrer would call Marigold, share the family’s contact information, and Marigold would contact the family directly. At other times, referrers told the family about the program but let the family contact Marigold themselves.

During Year 2, the case manager at Marigold was the primary recipient of all referrals. The case manager screened each family to determine eligibility and then the program director assigned the case to a therapist. The majority of interview respondents indicated the primary contact at Marigold to be the case manager. One respondent said the case manager was “articulate, professional, thorough, [and] adapts well to families.”

Interview respondents indicated that both girls and boys were referred to Marigold. According to Marigold staff, the program began accepting males into the program in fall 2003. Youth who were referred had mental health issues, problems in school, drug or alcohol issues, a need for close custody arrangements, or had problems getting other services. Some referrers considered whether the entire family was willing to “do some work” before making the referral. Those who were not referred to Marigold are youth who had extreme mental health issues, were criminal sex offenders, or were out of the service area.

Minorities

Many interview respondents had referred Hispanic families to Marigold and felt comfortable making these referrals. Several interviewees mentioned that an interpreter or bilingual therapist would supplement Marigold’s services, however, each indicated that this was not necessary in order for him or her to continue making Hispanic referrals to Marigold. Rather, respondents suggested that Marigold continue to work toward training a culturally competent staff.

Marigold staff mentioned the therapists’ lack of diversity as a barrier in reaching minority groups. Specifically, staff indicated that those referring Native Americans often preferred to refer to counseling services on the reservation or to Native American service providers. Marigold staff also indicated that they were missing a connection by not having a Native American referral source. According to one interview respondent, “Marigold hasn’t made a good attempt to serve Native American youth.”

Request for follow-up

Marigold staff indicated that the therapists make some connection with the referral source after receiving the referral. Therapists often call the referral source back after they have met with family if the family has signed a release of information form. Marigold typically shared only minimal information with the referral source because the FFT model encourages limited contact with the referrer.

However, numerous interview respondents requested increased feedback from Marigold on the families that they have referred. One respondent explained that if a referrer sends a family to contact Marigold for services, the referrer was often unaware if the family ever made contact with Marigold. According to multiple interview respondents, Marigold could improve its services by providing the referrer with an update on family progress. Several interviewees said that Marigold has contacted them regarding a family but that this contact was only to ask them for information, not to provide an update. One respondent indicated receiving progress updates from a Marigold therapist in the past; however, the respondent also indicated that he/she would like to receive more updates.

Screening for Services

Sixty percent (58 youth) of those referred to Marigold during Year 2 completed an intake assessment (also called a “zero session”). Almost one-third of intakes (29%, or 17 youth) occurred on the same day as the referral. Over half of intakes (52%, or 30 youth) were within four days of the referral. One interview respondent noted that there was little lag time between the referral and Marigold’s contact with the family.

Referral data provide some insight into the reasons why 29 referred families failed to take part in an intake, or zero session. Of the documented case notes, thirteen families were not available, meaning that program staff tried to contact families and left multiple messages without success. In eight cases, the family’s living situation was highly unstable. For instance, families were homeless, living

in a shelter or planning to relocate in the near future. Marigold provided a referral to another (usually counseling) service for seven families. Four referred youth did not meet the age eligibility criteria. Chapter 6 provides suggestions on how to more fully document the reasons why Marigold fails to provide some clients with a zero session.

JCP data

In December 2002, Marigold began recording JCP Risk Screen scores. The JCP is an assessment tool that contains “at-risk” indicators in five domains and is used to determine eligibility for Marigold’s services. To be eligible for Marigold’s services, youth are required to have a minimum of two “at-risk” JCP indicators. JCP data were recorded for 55 youth during Year 2. Of the youth with JCP risk data, all had a least one risk indicator in the Family Functioning Domain, 83% (45) had one or more risk factors in the Behavioral Issues Domain, 78% (43) had risk indicator(s) in the School Domain, 69% (38) were at risk in the Peer Relationships Domain, and 52% (29) had at least one risk factor in the Substance Abuse Domain.

Of the youth with JCP risk data, the total number of positive at-risk responses ranged from 2 to 20, with an average of 10 risk responses per youth. Marigold provided services to 42% (23) of those with JCP data. It is unclear as to why this portion of youth engaged in Marigold’s services while others did not. (See Chapter 6 for documentation recommendations for future years.)

Furthermore, those who received services from Marigold had a lower average number of positive at-risk responses compared to those who did not receive Marigold’s services. The average number of positive at-risk responses for youth who received services from Marigold was 9, while the average for youth who did not received services from Marigold was 11. As discussed further in Chapter 6, more information is necessary to determine why those who scored as higher risk did not receive Marigold services.

Summary

It is evident that Umatilla County service providers are beginning to recognize Marigold as a resource in the community. The number of referrals to Marigold has more than doubled between Year 1 and Year 2, and the number of service providers referring to Marigold has also increased. However, there was evidence that some community partners were uncomfortable with making Native American referrals to Marigold.

According to all referral sources, Marigold’s referral process was easy and highly accessible. The short length of time between the referral and the intake session shows Marigold’s proficiency in receiving and processing referrals. Finally, a number of referral sources conveyed the desire to have family progress updates provided by Marigold.

Chapter 3: Families Served

This chapter describes the families Marigold served during Year 2 (N=30) and all families served since the program inception (N=59). However, for certain types of information, only partial data (about 50%) were available for Year 2 families (family living situation, school and education information, and drug and alcohol abuse history). For these areas, we report only combined Year 1 and Year 2 data (see Chapter 6 for a further discussion of this issue). Included in this chapter are demographic characteristics, assessment scores, and presenting issues.

Demographics

Age and Gender

Marigold gathers a variety of demographic information at intake about the families it serves. Since Marigold inception, the youth served by Marigold have ranged in age from 11 to 18 (average age of 15) at the time of intake. During Marigold's first year, 100% (29) of the youth served were girls; during Year 2, 83% (25) were girls and 17% (5) were boys.

Ethnicity and Language Spoken

Marigold collected ethnicity information from 25 youth in Year 1 and from 29 youth in Year 2. During Year 2, Marigold served 23 (79%) Caucasian youth, 4 (14%) Hispanic youth, and 2 (7%) youth who identified as an "other" ethnicity. Of those with a JCP screening during Year 2, two youth (8%) indicated that his or her first language was Spanish. Since program inception, Marigold has served 43 (80%) Caucasian youth, 5 (9%) Hispanic youth, 3 (6%) American Indian youth, and 3 (6%) youth who identified as an "other" ethnicity.

Family Living Situation

Over one-third (39% or 16) of the youth Marigold has served during the past two years lived with their mother at the time of intake. Fifteen percent (6) lived with a mother and stepfather, and 12% (5) lived with both biological parents. Four youth (10%) lived with a father only, 3 with other relatives (7%), 2 with friends (5%) and 2 with partners (5%). In 40% (15) of the families Marigold served, the youth's parents were married. In over one-third (37% or 14) of the families, the youth's parents were divorced. The remaining parents were single (13% or 5), separated (5% or 2) or widowed (5% or 2).

School and Education

Over the past two years, seventy percent (30) of the youth attended school while they received services from Marigold. The majority of these youth were in grades 9 through 12. Almost one-fifth (19% or 6) of those enrolled in school were in an alternative school. Although the majority of youth were averaging passing grades (56%), slightly more than one-quarter was receiving D's (26%) as average grades and nearly one-fifth (19%) were receiving failing grades. The highest level of education the mothers had obtained ranged from grade school to college graduation. Half of the mothers (50% or 12) had attended at least some college, while slightly over two-fifths (42% or 10) had attended at least some high school. Two mothers (8%) had only a grade school education.

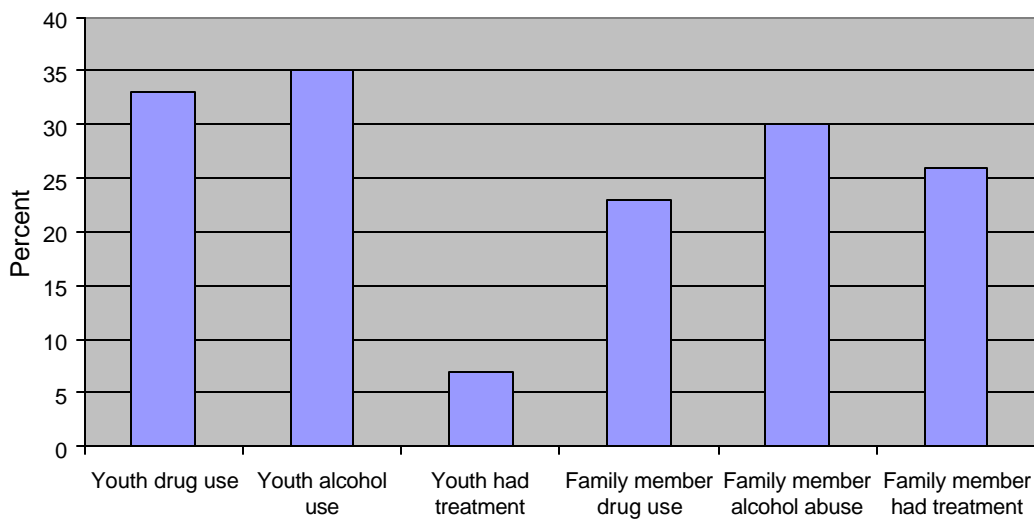
Drug and Alcohol Abuse

Marigold staff members collected data about substance abuse among the youth and their family members. At intake, 33% (14) of the youth admitted that they currently use drugs and 35% (15)

were using alcohol. Three youth (7%) had previously been to drug or alcohol treatment. Substance abuse was common among family members as well: more than one-fifth of the youth (23%, or 10 youth) had family members who used drugs, and nearly one-third (30% or 13) had family members who abused alcohol. More than one-quarter (26% or 11) had a family member who had been to drug or alcohol treatment. Figure 2 illustrates these substance abuse data.

According to national statistics, a greater proportion of Marigold families have substance abuse issues compared to American families. The National Institute on Drug Abuse (1994)³, estimated approximately 6% of American parents use drugs and approximately of 8% of American parents abuse alcohol. Thus, percentages of Marigold families who use drugs and abuse alcohol are considerably higher than national statistics.

Figure 2. Substance Abuse History for Marigold Families (N=43)

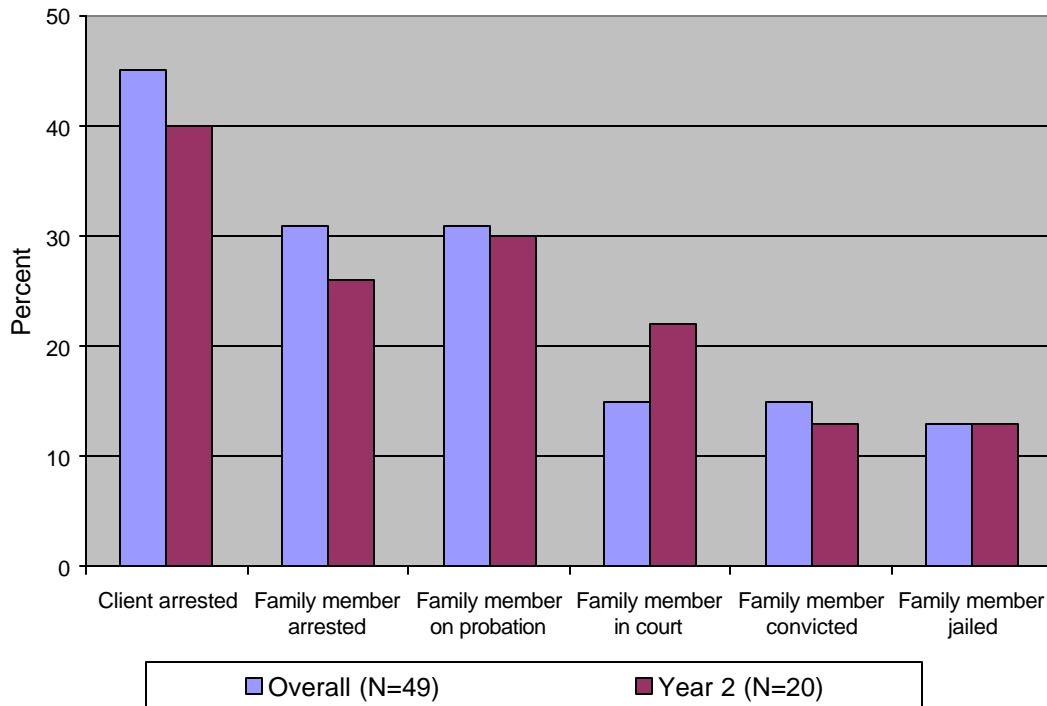


Involvement with the Criminal Justice System

Over the past two years, Marigold staff collected data on each family's involvement in the criminal justice system. Overall, 45% (22) of the youth had been arrested, 31% (16) of the youth had a family member arrested and 31% (16) had a family member on probation, 15% (8) of the youth had a family member in court, 15% (8) had a family member convicted, and 14% (7) had a family member spend time in jail. Figure 3 shows these percentages for all clients served in the two years Marigold has been in operation as well as for only those clients served in Year 2.

³ NIDA. (1994). *Substance Abuse Among Women and Parents*. [On-line]. Available: <http://aspe.hhs.gov/hsp/cyp/xsfamdrng.htm>.

Figure 3. Criminal History for Marigold Families



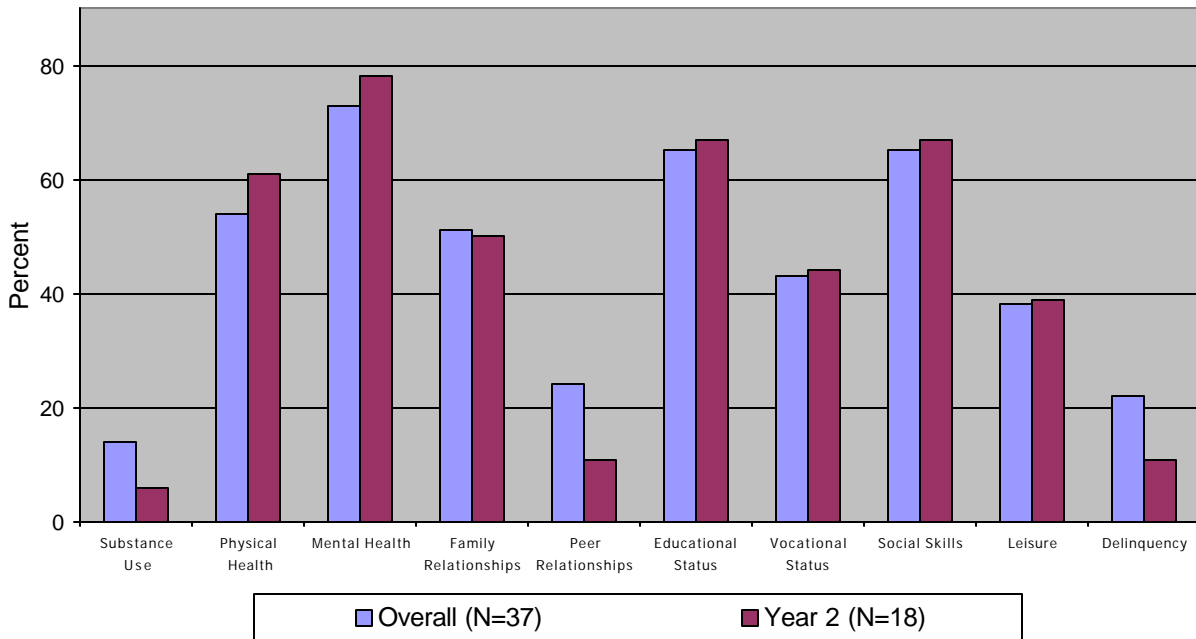
Assessment Scores

The youth and their families completed a range of assessments at intake. These assessments measured individual (youth) functioning, family functioning, and the degree of adolescent risk behavior.

Problem Oriented Screening Instrument for Teenagers (POSIT)

During Year 1, Marigold youth completed the Problem Oriented Screening Instrument for Teenagers (POSIT) at intake and during the final therapy session. Intake and exit POSIT scores were compared to show change in risk areas. However, in Year 2, the POSIT was only administered at intake to a portion of youth, as FFT discontinued the use of the POSIT during Year 2. Therefore, the POSIT intake scores presented below represent all Year 1 clients and only a portion of Year 2 clients. The POSIT contains ten subscales that are scored in terms of the degree of risk (low, middle, and high). Figure 4 illustrates the percentage of youth scoring as high risk on each subscale. Particularly problematic areas included physical health, mental health, educational status, and social skills.

Figure 4. Percentage of Youth who scored High Risk on the POSIT



The Outcome Questionnaire (OQ45.2)

The OQ45.2 is a self-report assessment that measures the client’s level of depression and anxiety (the Symptom Distress subscale), problems with interpersonal relationships (the Interpersonal Relations subscale), and levels of conflict and isolation in interpersonal relationships (the Social Role subscale). Initial scores on the OQ45.2 suggest that the majority of youth had scores in the clinical range on all three subscales (see Table 1 below).

Table 1. Percentage of Families served in Year 2 with OQ45.2 Scores in Clinical Range

Subscale	Adolescent (N=24)	Mother (N=23)	Father (N=12)
Symptom Distress	75%	48%	17%
Interpersonal Relations	58%	44%	33%
Social Role	79%	35%	33%

*Subscales with 50% or more in clinical range are shaded gray.

Average scores on the OQ45.2 illustrate that the youth had high levels of depression and anxiety, problems with interpersonal relationships, and high levels of conflict and isolation in interpersonal relationships. Tables 11 and 12 in Appendix A list the average OQ45.2 scores for the youth, their mothers, and fathers in Year 2 and for all Marigold families.

The Family Assessment Measure (FAM)

The Family Assessment Measure (FAM) is a self-report instrument that provides information on the family’s strengths and weaknesses in seven areas. As Table 2 illustrates, 50% or more of the mothers

and fathers receiving services from Marigold in Year 2 fell in the clinical range on the Task Accomplishment Subscale (indicating they had problems with basic tasks or identifying solutions to problems). The majority of youth and parents had clinical-level scores on the Communication Subscale, indicating problems with communication or a lack of understanding of other family members. Half of the youth and their mothers scored in the clinical range on the Affective Expression Subscale, indicating they either lacked sufficient expression or had overly emotional responses. At least 50% of youth and their fathers displayed insufficient family involvement, a lack of autonomy or narcissistic involvement, as indicated by the Involvement Subscale. More than half (64%) of fathers exhibited power struggles, use of control to shame, and lack of ability to adjust to changing life demands (the Control Subscale). Half of mothers held disjoined values systems, which resulted in family tension and confusion as measured by the Values and Norms Subscale.

Table 2. Percentage of Families served in Year 2 with FAM Scores in Clinical Range

Subscale	Adolescent (N=22)	Mother (N=20)	Father (N=11)
Task Accomplishment	32%	50%	55%
Role Performance	41%	40%	27%
Communication	55%	50%	73%
Affective Expression	50%	50%	36%
Involvement	46%	50%	55%
Control	27%	45%	64%
Values and Norms	32%	50%	46%

*Subscales with 50% or more in clinical range are shaded gray.

Youth Outcome Questionnaire (YOQ)

The Youth Outcome Questionnaire (YOQ) is a parent report measure of observed adolescent behavior. Mothers and fathers completed a YOQ at intake. Initial scores on the YOQ show that the majority of parents rated their child in the clinical range on all subscales, with the exception of the Interpersonal Relations Subscale. *Average* scores show the same results for Year 2 and for all Marigold families. (See Tables 13 and 14 in Appendix A.)

Table 3. Percentage of Families served in Year 2 with YOQ Scores in Clinical Range

Subscale	Mother (N=20)	Father (N=9)
Interpersonal Distress	75%	78%
Somatic	80%	56%
Interpersonal Relations	0%	0%
Social Problems	85%	89%
Behavioral Problems	65%	78%
Critical Items	95%	78%

*Subscales with 50% or more in clinical range are shaded gray.

Presenting Issues

Therapists included in their case notes descriptions of the families' presenting issues and problems. Several common themes emerged in these descriptions. Many (19 families) described their child as acting out, getting into fights, disobeying authority figures, or generally lacking respect for others. The next most common theme (discussed by nine families) was educational problems, for instance, skipping school, doing poorly in school, or getting in trouble at school. Six families mentioned that either the parent and/or the child had a substance abuse problem. Another six families mentioned parenting issues as the primary problem, such as verbally abusive parents, parents who are non-responsive or overwhelmed, or parents who lack control or discipline in their own, and in their children's lives. Four families mentioned their youth's struggle with depression, withdrawal, or weight issues as the primary area of concern.

Summary

Based on demographics, assessment scores, and presenting issues of the families served by Marigold, the program is reaching its target population. The youth served in Year 2 were within eligibility age range and the majority of youth served were girls. Youth exhibited multiple risk factors including substance use, criminal involvement, physical and mental health issues, and problems with individual and interpersonal functioning.

Chapter 4: Marigold Services

This chapter provides an overview of the services that Marigold provided during Year 2. The chapter begins with a summary of caseloads and staffing and then details the program's use of, and adherence to, the FFT model. In addition, this chapter provides a brief discussion of targeted client populations: Hispanic and Native American families, and new services for at-risk boys. Finally, the chapter concludes with a description of the case management services provided by Marigold.

Caseloads & Staffing

During Year 2, Marigold staff consisted of the program director/clinical supervisor, two therapists, and a case manager. Each therapist has a maximum caseload of 12 families, and by the spring of 2003, the therapists' caseloads were often near, or at, capacity. The program director also served as a therapist with a reduced caseload (between 3 and 5 families). During Year 1, one of the primary concerns of program staff was the ability to recruit an adequate number of clients for the program. During Year 2, in contrast, the program had enough clients to fill the therapists' caseloads. In fact, during the spring of 2003, the program briefly had to place families on a waiting list for services. Respondents attribute the increase in clients to the state budget crisis, which resulted in cutbacks in publicly provided services.

While the program director, case manager, and one of the therapists have been with the Marigold program since program inception, there was turnover in the second therapist position. The original therapist hired for the position left Marigold in the summer of 2003. The next therapist hired stayed only briefly, and a third therapist was hired in January 2003. Increased experience with the clientele and with the FFT model allowed the Marigold program director to use specific criteria to make better-informed hiring decisions. When the original program staff members were hired for the program, none had used the FFT model, and none had prior knowledge about the qualities and attributes that could lead to a therapist's comfort with the model and with clients. For example, Marigold therapists must be comfortable working with families in their homes and must be comfortable working with families exhibiting multiple challenges. The current program staff all are comfortable with the clientele and with the FFT model.

Use of FFT

Marigold therapists took part in continued training activities during Year 2. The newest therapist participated in the initial FFT training, while the more experienced therapist took part in an externship facilitated by FFT. According to Marigold staff, the training and externship provided by FFT were helpful, but did not fully prepare therapists for their work in the field. As one therapist stated, "the FFT training was good but left me with a lot of learning to do after I got to Marigold." The therapists agreed that observing the FFT supervisors using the model, during training and during externship, was interesting and beneficial. Indeed, the therapists thought that more of this observation would be helpful for their FFT practice.

During the first year of the program, Marigold staff members had a weekly telephone call with a supervisor from FFT. Subsequently, the Marigold program director was selected by FFT to become one of the national FFT supervisors, and therefore, during Year 2 she was able to provide the clinical supervision of Marigold staff herself. Marigold therapists met with the program director on a weekly basis for FFT consultation. The therapists indicated that this helps to keep them "on track" with the FFT model. The program director had training and supervision telephone conferences with

a FFT national consultant every other week. These calls allowed her to further her knowledge of the model and hone her clinical supervision skills, and also allowed FFT to monitor Marigold’s adherence to the therapy model. The fact that the program director was selected by FFT to become a national FFT supervisor illustrated FFT’s belief that Marigold had high proficiency with, and adherence to, the model. Indeed, in Year 2, Marigold staff continued to gain more confidence and skill with the FFT model. All of the Marigold staff indicated that they enjoyed working with the FFT model. One staff said, “the model is elegant and simple.” Another staff member appreciated the structure, goals, and progression of the model. The therapists believed in the effectiveness of the model and believed that it works for the families they were serving.

FFT therapists completed case notes at the end of each counseling session. These notes provide a rich source of information about the issues addressed in the counseling session, the strategies used by the therapists, the progress the family was making, and the degree of confidence the therapists had in their assessments and ratings of the family. When a family was in the first phase of the model (Engagement and Motivation), counselors reported on the importance of six Phase 1 goals for the family, along with the progress the counselors believed they have made in each session toward those goals. Counselors ranked the “developing an alliance,” “creating a relational focus,” and the “creating the idea that there is a good solution to the family’s problems” goals as important most often. Indeed, in all Phase 1 sessions, developing an alliance with the family was rated as somewhat or very important. Table 4 lists the six Phase 1 goals and the percentage of sessions for which each goal was ranked by therapists as somewhat or very important.

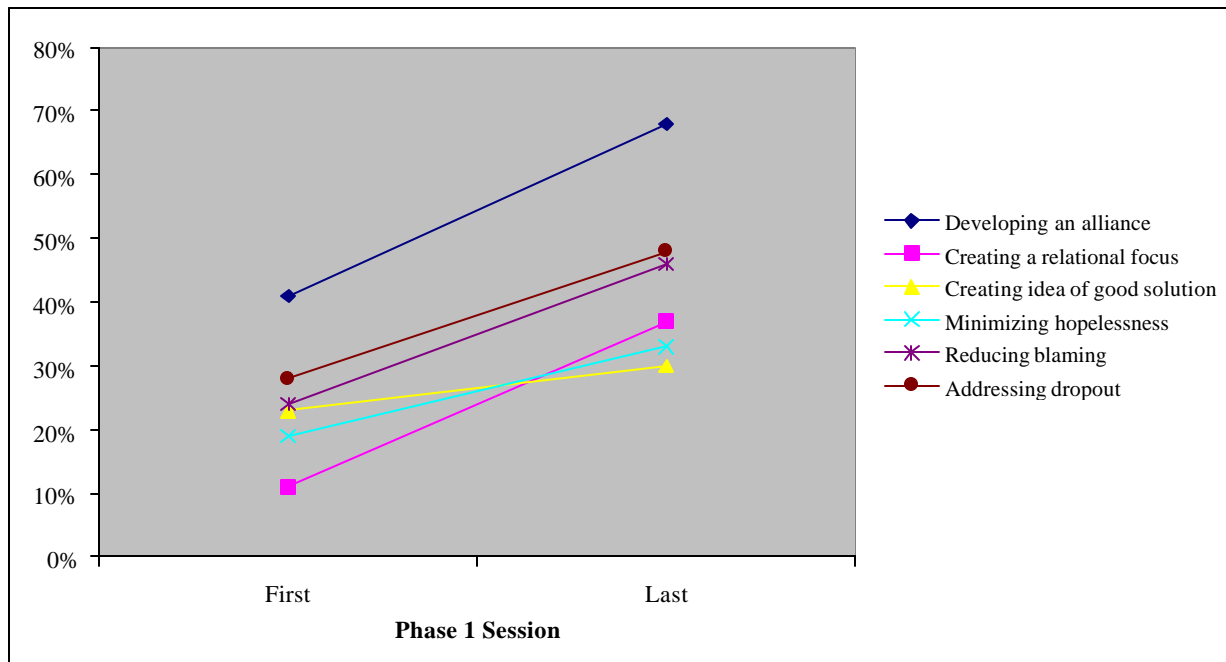
Table 4. Phase 1 Goals

(N=196 Phase 1 Sessions)

Goal	Percent of sessions for which this goal is ranked as important
Developing an alliance	100%
Creating a relational focus	99%
Creating idea that there is a good solution to the family’s problems	97%
Minimizing hopelessness	90%
Reducing blaming	78%
Addressing indicators of dropout	70%

Counselors also ranked how much progress they believed they have made at each session with the family on each goal. Figure 5 illustrates the percent of Year 2 families with whom counselors felt they made good or significant progress toward each goal in the first and last Phase 1 counseling sessions.

Figure 5. Percentage of Year 2 Families Rated with Good Progress on Phase 1 Goals (N=27)

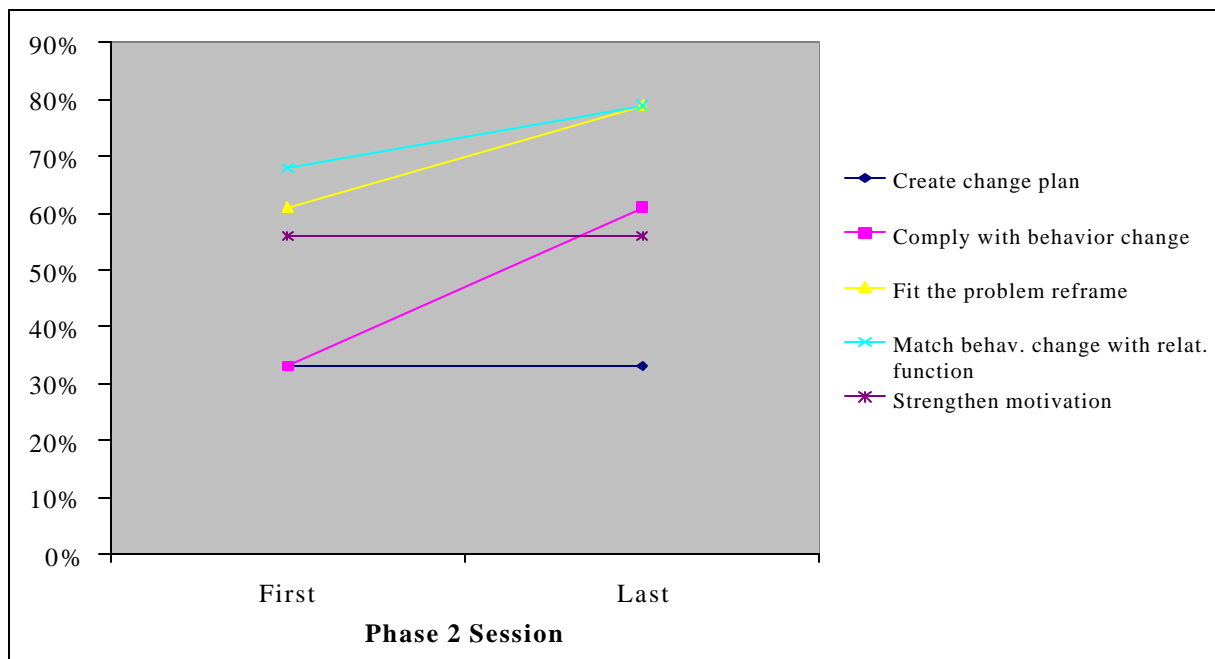


The data in Figure 5, above, illustrate that as counselors progressed through the Phase 1 sessions with their clients, they reported increased progress on the Phase 1 goals. For example, after the first session, counselors reported that they made good or significant progress on developing an alliance 41% of the time, while after the last session counselors reported good or significant progress on this goal 68% of the time. Overall, counselors reported greater progress with some goals than with others. Some Phase 1 goals, in fact, showed low progress ratings. For example, counselors reported good or significant progress on building a relational focus only 11% of the time after Session 1 and 37% of the time after the last Phase 1 session. While this does represent progress over time, it nevertheless indicates that counselors often found it difficult to make progress on this goal. Similarly, counselors reported good or significant progress on creating an idea that there is a good solution to the family's problems only 23% of the time after Session 1 and 30% of the time after the last Phase 1 session. It is worthy of note that these two goals were two of the most commonly selected by the therapists as important for families. Thus, progress appeared to be most difficult for some of the most important goals. The results reported here for Year 2 families mirror the results for all families served by Marigold since program inception.

Therapists also provided a series of ratings in Phase 1 about the relationship between each of the family members. These ratings indicated the counselors' assessments of the relatedness and hierarchy between the client and her parents. While these ratings have clinical use and are not relevant to the evaluation of the Marigold program, therapists also indicated their confidence with the ratings they make. It is possible to examine these ratings to see whether therapists' confidence increases over time. The data indicate that therapists' confidence in their assessments of family relations was high and increased over the course of Phase 1. Therapists indicated they were somewhat or very sure of their assessments over 70% of the time after Session 1 and 100% of the time after Session 5.

During Phase 2 (Behavior Change), therapists also ranked the importance of several goals for each family, along with how much progress was made towards those goals. The Phase 2 goals are “creating a change plan,” “complying with behavior change,” “fitting the problem reframe,” “matching behavior change with relational function,” and “strengthening the family motivation.” Therapists ranked *all* Phase 2 goals as somewhat or very important. Figure 6 displays the percent of families rated as making good or significant progress on the Phase 2 goals for the first and last session of the Phase. In general, therapists’ progress ratings were high for the Phase 2 goals; however, progress ratings for “creating a change plan” remained low throughout Phase 2 sessions; good or significant progress was indicated only approximately one third of the time. Progress ratings for “strengthening the family motivation” also remained stable across the Phase 2 sessions; therapists reported good or significant progress on this goal for just over 50% of the families at the first and last Phase 2 session. Therapists did report progress over time on three of the five Phase 2 goals, however: good or significant progress ratings for “matching behavior change with relational function” increased from 68% to 78%; good or significant progress ratings increased for “fitting the problem reframe” from 61% to 78%, and good or significant progress for “complying with behavior change” ratings increased from 33% to 61%. Data analyses of all families served by Marigold since program inception indicate results similar to those for the Year 2 families alone.

Figure 6. Percentage of Year 2 Families Rated with Good Progress on Phase 2 Goals (N=18)

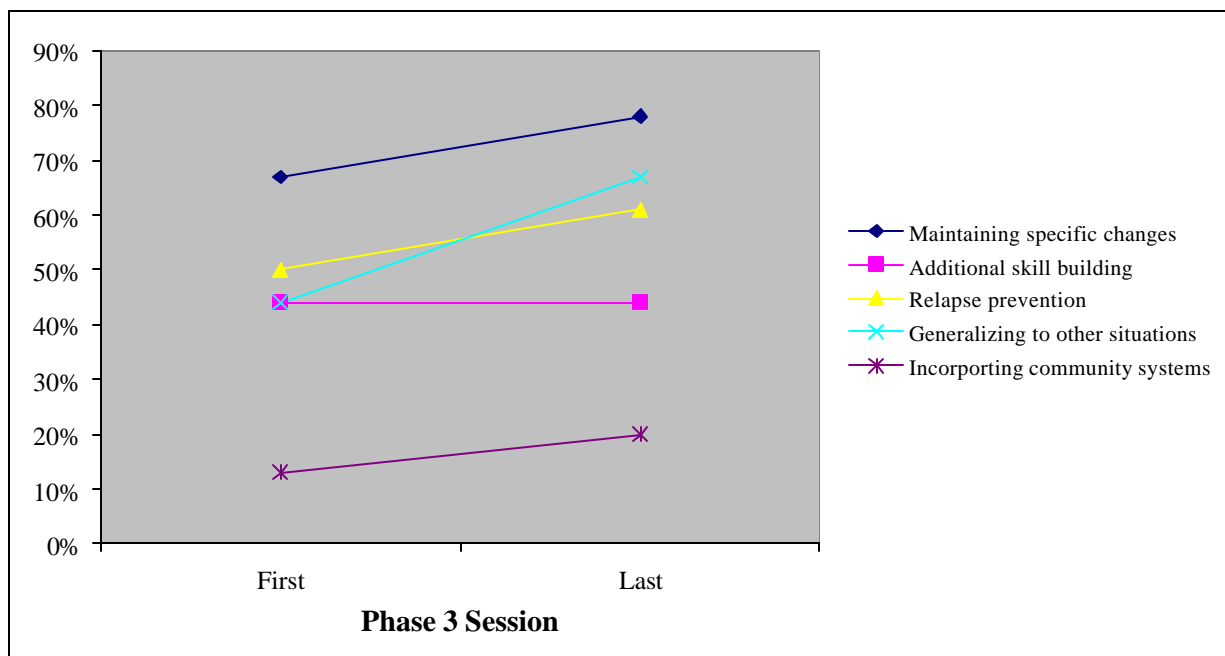


Therapists also made note of FFT strategies, or themes, that they used to reframe the problem during Phase 2. Therapists indicated use of eight themes, though some were used far more frequently than others. The most frequently used themes included “anger implies hurt,” “nagging equals importance,” and “protection.” The themes used less frequently included “need to feel OK about self in the context of problems,” “anger implies loss,” “pain interferes with listening,” “defensive behavior implies an emotional link,” and “frightened by difference.” The more frequently used themes were mentioned by therapists more than a dozen times, while the least frequently used themes were mentioned only several times. The discrepancy in the frequency of use

of the reframe themes may be due to therapists' comfort level with some themes, or therapists could believe that some themes are more useful for the families served by Marigold.

During Phase 3 (Generalization), therapists reported the importance of five goals: "maintaining specific changes," "additional skill building," "relapse prevention," "generalizing to other situations," and "incorporating community systems into treatment." Too few Year 2 families have completed Phase 3 of the model to allow for independent analysis of this group. Instead, reported here are the Phase 3 goal ratings for all clients served since program inception. Three of the goals were rated as somewhat or very important after almost every Phase 3 counseling session: "maintaining specific changes," "relapse prevention," and "generalizing to other situations." Figure 7 displays the percent of families rated as having good or significant progress on each Phase 3 goal at the first and last Phase 3 session. As illustrated in the figure, therapists indicated progress between the first and last session of the Phase for most goals. However, therapists indicated that they made good or significant progress with approximately 40% of families on the "additional skill building" goal, and therapists indicated that they made good or significant progress with less than 20% of the families on the "incorporating community systems into treatment" goal. The low ratings on this latter goal could be due to the fact that Marigold employs a case manager who addresses families' needs for community resources, and therefore, the therapists themselves do not need to address this goal within therapy. Alternatively, the families served by Marigold may be fairly high functioning in terms of meeting their basic needs, and therefore linking families with community systems is not a focus for therapists.

Figure 7. Percentage of Families Rated with Good Progress on Phase 3 Goals (N=18)



The results presented above are predicated upon the assumption that the importance rating for each goal remains constant throughout a phase and that therapists seek to improve progress on phase goals throughout the phase. Therefore, examining change between the first and last session of a phase is a useful measure of this progress. However, there is an alternate approach to examining goal progress. Marigold staff have discussed that they should begin to use their counselor notes to

capture “snapshot” information about the particular counseling session, rather than overall progress on a particular goal throughout the phase. In this approach, if a particular goal is addressed successfully, for example during the first or second sessions of a phase, one would expect to see high progress for this goal at those sessions, and then progress ratings for this goal would drop during subsequent sessions (simply because the goal is no longer being addressed). Because Marigold therapists all will use this alternative approach in Year 3, the type of analyses presented above will no longer be appropriate. Instead, in future evaluation reports, the importance ratings for goals at each individual session will be compared to the progress ratings for those same goals at each session.

Another means for investigating the therapists’ use and adherence to the FFT model is through the families’ scores on the Counseling Process Questionnaire (CPQ). Adolescents and their parents complete this questionnaire after their first counseling session, and after every third counseling session thereafter. The CPQ is divided into three subscales to mirror each of the three phases of the FFT model: an engagement and motivation subscale, a behavior change subscale, and a generalization subscale. CPQ items ask clients to rate the degree to which they feel their counselor is working with them on the various goals and facets of each phase. It is useful to investigate change in subscale scores over time. It could be expected, for example, that generalization subscale scores would increase as families enter that phase of the FFT model. However, change scores (the difference between the first and second, second and third, and first and third CPQ) for those individuals who completed three CPQs (12 adolescents, 11 mothers, and 8 fathers) indicate that there was *not* significant change in subscale scores over time. That is, individuals’ engagement scores, behavior change scores, and generalization scores remained fairly constant over time. These results should be interpreted with caution given the small sample sizes. It will be interesting to continue to monitor CPQ subscale change scores as more individuals complete multiple CPQ administrations.

In addition to change scores, it is possible to look at the overall average scores on each subscale for each CPQ administration. Table 5 lists the CPQ subscale scores for the first (Session 1), second (Session 4), and third (Session 7) CPQ administrations⁴.

⁴ Scores for subsequent CPQ administrations are not shown here due to small sample sizes.

Table 5. CPQ Scores

	1 st CPQ	2 nd CPQ	3 rd CPQ
Adolescent	(N=40)	(N=29)	(N=12)
Engagement Score	32	32	35
Behavior Change Score	31	31	33
Generalization Score	19	19	19
Mother	(N=34)	N=(25)	(N=11)
Engagement Score	33	33	35
Behavior Change Score	34	31	34
Generalization Score	19	20	21
Father	(N=22)	(N=13)	(N=8)
Engagement Score	30	30	30
Behavior Change Score	29	30	30
Generalization Score	18	18	18

The maximum score for the engagement and behavior change subscales was 42, and the maximum score for the generalization subscale was 28, and therefore all the average scores on each subscale were relatively high. Thus, families reported that they felt counselors were helping them progress toward the goals of the FFT phases throughout the duration of therapy.

Serving Targeted Populations

As described in Chapter 3, most Marigold clients were Caucasian girls and their families. However, the program was open to all families, and it has served a small number of Hispanic families. Marigold had no bilingual staff, and as a result, for several families, the youth translated for another family member during counseling sessions. While some staff acknowledged that this works “well enough,” one staff member asked, “how do I engage the parent that doesn’t speak English?” Parents may feel frustrated and left out of the loop if they must rely on their children to translate, and parents could have concerns over the accuracy or bias in the youths’ translation.

Marigold has had even more difficulty serving Native American families. Some Native American families have been referred to Marigold and the program had difficulties working with these families. Marigold staff indicated that those from the reservation might not be open to Marigold’s services. For the Native Americans families that Marigold has counseled, there have been cultural barriers that seem to prohibit services.

As described in Chapter 2, Marigold started serving boys in the fall of 2003. While the program continues to have a primary focus on girls and their families, community partners and referring agencies expressed a desire to have FFT services available to the boys they serve as well. Therefore, Marigold decided to be responsive to the need for such services for boys, but capped the number of boys served at any one time to five. Staff members indicated that the program could easily get overwhelmed with referrals for boys, and as a result, they will cap the number of boys served in order to ensure adequate spaces for girls. The program was originally funded as a girl-specific service, and therefore Marigold staff members did not want to dilute this primary mission. Because

the program accepted only a small number of boys, Marigold did not broadly publicize the fact that the program started serving boys. Instead, they told several key referral sources who provided referrals for boys and their families.

The therapists applied the FFT model in the same fashion when working with boys and girls. Some Marigold staff members have found that the presenting issues for boys and girls can be different. For example, some boys exhibited more externalized aggressiveness and acting out behavior, whereas some girls were more likely to come to Marigold with eating disorders, depression, or other health issues. Several stakeholders said that the services to boys have been “really beneficial.” Staff and other stakeholders consistently indicated that Marigold’s acceptance of boys into the program had not limited services to girls in any way: “girls are the priority at Marigold.”

Case Management

Marigold’s use of case management services had been one challenging area in the past, in terms of FFT model adherence. Case management is not a part of the FFT model, and during Year 1, program staff struggled with how to provide what they saw as a necessary service while at the same time retaining fidelity to the FFT model. Program staff experimented with different ideas of how to integrate case management into the FFT model during Year 1, and toward the end of the first year began holding off on case management services until the end of a family’s involvement in the program. This system was solidified in Year 2: unless there was an immediate safety issue, the case manager noted the family needs at the initial session, gave the family a resource list and waited until the family was in the last phase (the Generalization Phase) of therapy to provide case management services. There was an exception to this system, however. A therapist would ask the case manager to get involved with a case before Phase 3 if a family was at risk of dropping out of Marigold without the help of the case manager. For example, a family struggling with homelessness could not continue with counseling sessions until they first received help in securing stable housing. Typically, however, Marigold offered case management services in the last phase of therapy and “uses more prudence in utilizing case management services” than they used during Year 1.

Summary

Marigold staff continued to gain comfort and skill with the FFT model during Year 2. Additional experience with families along with continued trainings, in-service, and supervision from FFT headquarters have contributed to the staff’s growth and adherence to the model. The fact that FFT had chosen to train the program director as a national FFT consultant indicated a high degree of adherence to, and proficiency with, the model. Counselor case notes also reflected the counselors’ assessment of their progress with families on goals during each FFT phase. Ratings indicated that counselors felt they made good progress on a number of goals, while some goals reflected lower progress ratings. Program staff members also have successfully integrated case management services into the final phase of the FFT model.

During Year 2, the Marigold program staff continued efforts to serve Hispanic and Native American youth. While some Hispanic families have received services at Marigold, the lack of bilingual staff continued to be a barrier to serving more Hispanic families. The program also continued to have difficulty with engaging and serving Native American families. These challenges along with recommendations for Year 3 are discussed in Chapter 6.

Chapter 5: Client Retention and Outcomes

Retention

The Marigold program had a total of 16 completed cases during the first year of operation, and had 31 completed cases in Year 2. In addition to these closed cases, at the end of Year 2 there were an additional 21 active cases. Not all families successfully complete the Marigold program, however. During Year 1, seven families dropped out of the program at some point after their intake, but prior to completion, and during Year 2, 13 families dropped out after intake but prior to completion.

Those families who did *not* drop out of services received an average of 9.3 sessions, with a range of 3 to 17 sessions. These families spent an average of 4 sessions in the Engagement and Motivation Phase, 3.5 sessions in the Behavior Change Phase, and 1.4 sessions in the Generalization Phase. Only one family completed the program in only three sessions, and perhaps not surprisingly, the counselor gave this family the termination code of “non-significant outcome.” However, some families who received the termination code of “positive outcome” also completed the program quickly; one family completed the program in four sessions, and six additional families completed in less than ten sessions. Indeed, the average number of sessions for just those families with a “positive outcome” termination code is the same as the average number of sessions for all non-dropout families.

Most families who received an intake session but who did not complete the program dropped out of services between the third and fifth counseling session (6 families in Year 1 and 7 families in Year 2). In Year 1, no families dropped out after the first or second counseling session, but in Year 2, three families dropped out of services after the second counseling session. In Year 1, one family dropped out of Marigold after six or more counseling sessions, and in Year 2, three families dropped out after six or more sessions. Thus, not surprisingly, most dropouts occurred during the Engagement and Motivation Phase; most families who remain in counseling into the Behavior Change Phase stayed with the program through FFT completion.

Counselors made note of the reason for dropouts, and Table 6 illustrates the distribution of dropout reasons. Five adolescents (three during Year 1 and two during Year 2) moved away from Umatilla County and were unable to continue services. Two adolescents engaged in services in Year 1 ran away from home and therefore did not complete the program. Four families were dropped from the program during Year 2 after Marigold staff members were unable to contact them due to disconnected phones and incorrect addresses. The largest group of dropouts consisted of eight families (one from Year 1 and seven from Year 2) who failed to continue services despite repeated attempts by Marigold staff to schedule, and reschedule, future sessions. Once a family missed a session, Marigold staff attempted, via phone calls and visits to the home, to reschedule the appointment. Once a family missed three sessions, Marigold sent them a letter stating that they were being terminated from the program. As one staff member said, “If we don’t hear back from them at that point, we close the case.”

Table 6. Reasons for Dropouts

Reason	Year 1 Dropouts	Year 2 Dropouts	Total
Family refused contact	1	7	8 (40%)
Family moved away	3	2	5 (25%)
Staff unable to contact	0	4	4 (20%)
Youth ran away	2	0	2 (10%)
Youth incarcerated	1	0	1 (5%)
Total	7	13	20 (100%)

It is possible to examine the data for families who drop out to determine whether these families differ from the others in terms of demographics, assessment scores, and CPQ scores. Families who drop out of services have similar demographics and similar initial assessment scores on the FAM, OQ45, YOQ, and POSIT when compared to families who remain in services. However, there are three POSIT subscales on which the dropout youth score as higher risk: the substance use, family relationships, and peer relationships subscales. It is important to note, however, that the sample sizes are small, and as a result, statistical significance testing of these differences is not possible. Similarly, it is not possible to examine the JCP scores for those families who drop out of services because only three of these families started services since Marigold has been electronically recording JCP assessments. Analysis of the CPQ scores for those families who dropped out of services is limited due to the fact that many families dropped out before completing more than one or two CPQs. It is interesting to note, however, that families who drop out do not have lower CPQ subscale scores than families who remain in counseling. Perhaps contrary to expectations, the families who drop out do not exhibit higher risk, dysfunction, or lack of engagement with the FFT model than those families who remain in the program. As a result, it is not possible to determine from these data what factors may predispose a family to dropping out of Marigold's services.

Outcomes for Families

Included in the variety of information Marigold collects on the families it serves are intake assessments (as described in Chapter 3) and outcome measurement scores, as mandated by the FFT model. Families, upon exiting the program, complete the same assessment measures they completed at program intake, along with a Client Outcome Measure (COM). In addition, therapists also complete an outcome measure on the families. This section presents information on the outcome data for families who completed intake and exit assessments by June 30, 2003⁵. Data from these assessments indicated that individual and family functioning changed in several areas.

The Outcome Questionnaire (OQ45.2)

Sixteen youth completed the OQ45.2 at both intake and exit. Table 7 presents the number of youth with scores in the clinical range at intake and exit, and the difference between the two time periods

⁵ Reported in the text of this report and in Appendix B are data for matched pairs only; individuals with intake but no exit data, or exit but no intake data, are excluded from these analyses. However, Appendix C presents data on all family members who completed any assessment; thus, pre- and post-scores for the adolescents include the matched pairs described in this section of the report along with other adolescents who only had a pre- or post-score.

(negative numbers indicate change in the opposite direction as expected, or a higher number of youth scores in the clinical range at exit). Table 14 in Appendix B illustrates the *average* scores of youth at intake and exit, and the difference between the two time periods.

Table 7. Number of Family Members with OQ45.2 Intake and Exit Scores in Clinical Range

Subscale	Adolescent (N=16)		
	Pre	Post	Diff
Symptom Distress	8	9	-1
Interpersonal Relations	4	9	-5
Social Role	11	8	3

Contrary to what one would expect, five youth who did not score in the critical range on the Interpersonal Relations subscale at intake scored in the critical range upon exit, indicating that these youth had experienced increased problems with interpersonal relationships (the Interpersonal Relations subscale). There was little change in the youths' average scores on the three subscales.

Although 30 mothers completed the assessment at intake and 12 other mothers completed the assessment at exit, only six mothers completed the OQ45.2 at both times. These six mothers showed improvement on the Symptom Distress and Interpersonal Relations subscales. Additionally, three mothers (75%) who scored in the clinical range on the Interpersonal Relations subscales at intake had scores that fell within normal ranges upon exit.

Similarly, 16 fathers completed the assessment at intake and 10 fathers completed the assessment upon exit, however, only three fathers completed the OQ45.2 assessment at both times. Because of the extremely small number of fathers with assessments scores at both time periods, OQ45.2 outcome data for fathers are not included in this report.

The Family Assessment Measure (FAM)

Table 8 illustrates that youth improved on almost every subscale of the FAM. Most notably, on the Communication subscale, six youth who fell in the clinical range at intake fell within normal range upon exit. On the Task Accomplishment and Involvement subscales, four youth who fell in the critical range at intake fell within normal range upon exit. Youth also had significantly lower *average* scores in the areas of Task Accomplishment (with a difference of 9 points), Communication (10 points), and Involvement (10 points). See Table 15 in Appendix B for average pre and post-test scores.

Table 8. Number of Family Members with FAM Intake and Exit Scores in Clinical Range

Subscale	Adolescent (N=17)			Mother (N=13)			Father (N=10)		
	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff
Task Accomplishment	10	6	4	8	2	6	6	4	2
Role Performance	5	2	3	7	6	1	1	3	-2
Communication	13	7	6	6	3	3	5	5	0
Affective Expression	8	6	2	6	3	3	4	4	0
Involvement	10	6	4	6	3	3	3	2	1
Control	3	4	-1	5	2	3	6	4	2
Values and Norms	6	4	2	3	2	1	4	2	0

Likewise, the number of mothers scoring in the clinical range decreased on every subscale of the FAM. On the Task Accomplishment subscale, six mothers' scores that fell in the clinical range at intake fell within normal range upon exit. Average scores also decreased: mothers' scores significantly decreased on the Task Accomplishment, Communication, Affective Expression, Involvement, and Values and Norms subscales.

Father's average scores, on the other hand, changed only slightly, and in the opposite direction as expected. The average scores for fathers increased slightly on every subscale of the FAM. However, with the exception of the Role Performance subscale, the number of fathers scoring in the critical range remained stable or decreased slightly, as expected.

Youth Outcome Questionnaire (YOQ)

Overall, the results of mothers' and fathers' YOQ ratings of their child's behavior show mixed results (see Table 9). However, mothers' and fathers' *average* YOQ ratings illustrate slight improvements on the Interpersonal Distress subscale, the Interpersonal Relations subscale, the Social Problems subscale, and the Behavioral Problems subscale (see Table 16 in Appendix B).

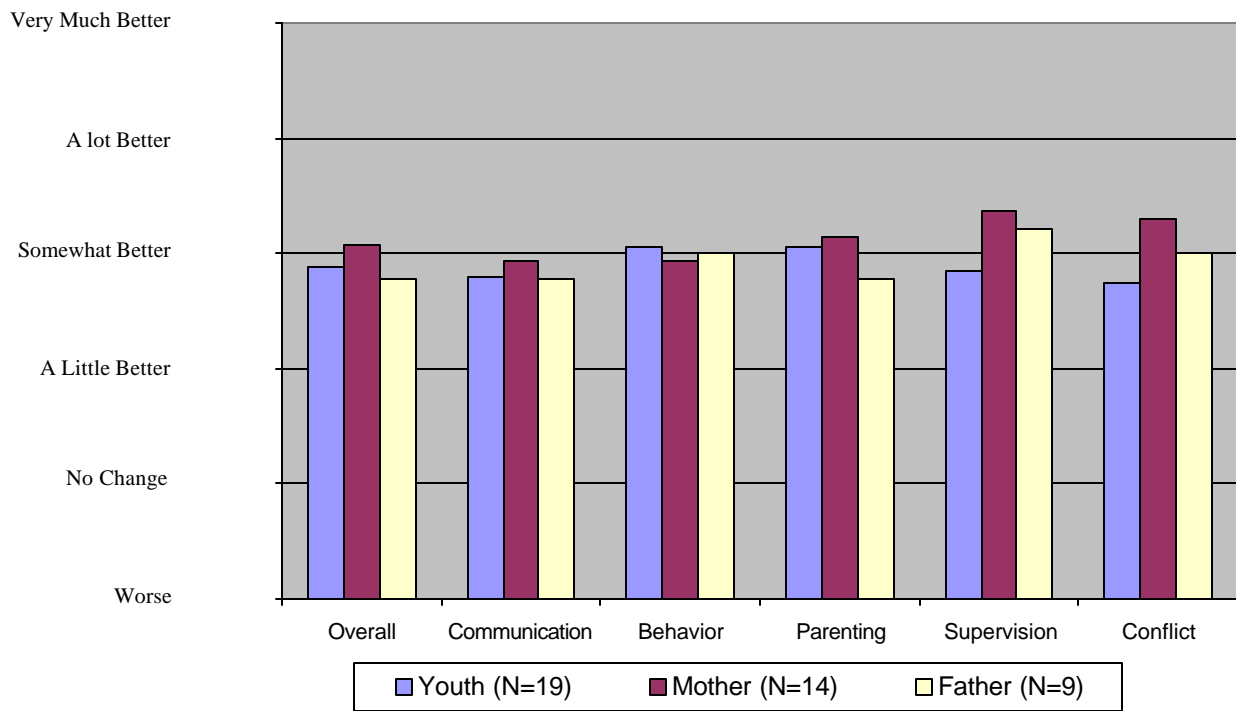
Table 9. Number of Family Members with YOQ Intake and Exit Scores in Clinical Range

Subscale	Mother (N=14)			Father (N=10)		
	Pre	Post	Diff	Pre	Post	Diff
Interpersonal Distress	10	8	2	7	4	3
Somatic	9	6	3	3	4	-1
Interpersonal Relations	0	0	0	0	0	0
Social Problems	7	10	-3	6	4	2
Behavioral Problems	7	8	-1	4	4	0
Critical Items	7	4	3	4	5	-1

The Client Outcome Measure (COM)

In addition to completing the assessments, youth and their parents provided information about their perceptions of how family functioning changed since counseling began using the Client Outcome Measure (COM), which is administered only at program exit. Individuals were asked to indicate how much overall change there had been in the family’s communication skills, in the youth’s behavior, in parenting skills, in parents’ supervision ability, and in conflict level since intake. As Figure 8 shows, most individuals indicated that each area of family functioning was “somewhat better.”

Figure 8. Average COM Responses



The Therapist Outcome Measure (TOM)

Therapists completed their own version of the Client Outcome Measure at program intake and at program exit. The Therapist Outcome Measure (TOM) provides information about the therapists' perception of family relationships, parenting, punishments, and rewards. Not unlike the results of the COM, the majority of TOM scores indicated that overall family functioning was "somewhat better" at the completion of therapy.

Therapists' responses on the pre-test and post-test showed family improvements in several areas. Therapists rated only five of twenty-two parents (23%) as having "good supervision" at the time of the initial assessment (as opposed to "some supervision" or "inadequate supervision"). Upon program discharge, therapists indicated that half of the families (50%, or 11 families) had "good [parental] supervision." At intake, therapists indicated that only three out of twenty-two youth (14%) were provided opportunities to participate in decision-making, while upon exiting from the program, thirteen (59%) of the youth were provided with this opportunity, according to therapists. At program entry, therapists indicated that five of thirteen of youth (39%) were "close to their father;" upon exit, seven of the thirteen (54%) were "close to their father." There was also some evidence of slight decreases in family conflict. However, there was little change in therapists' ratings of parents' use of appropriate punishment and rewards. It is important to note that these families entered therapy with some significant challenges, and therefore even modest improvements in the families' and therapists' perceptions of family functioning is encouraging.

Future Outcome Analyses

Future outcome analyses may include an explanation of whether there is a difference in improvement scores depending on whether the reporting parent is a biological parent or a stepparent. Future outcome analyses may also include reporting *family* scores [or an average of the youth's and parents' scores]. Marigold provides services to the entire family, and therefore it may be useful to treat the whole family as a unit. However, at this time, the number of cases for these analyses are very small and therefore, results would not be meaningful.

Summary

These outcome data indicate that youth and their parents showed some changes over the course of therapy. Mothers showed improvement on two of the OQ45.2 subscales. Youth and mothers showed improvement on almost every subscale of the FAM (while fathers' scores showed mixed results). Mothers' and fathers' YOQ ratings of their children's behavior showed some improvements and scores from the COM and the TOM indicated that family functioning was "somewhat better" at the close of therapy.

It is important to keep in mind that these outcome data are on only a small subset of Marigold families. For families that complete the program, it is essential for program staff to have every family member (initially assessed) complete each outcome measurement at the final session. These data will help to document the program's effectiveness and the change in the lives of these families.

Chapter 6: Program Successes, Challenges, and Recommendations for Year 3

This final chapter of the Year 2 Evaluation Report begins with a discussion of the program's successes during this past year. The chapter then goes on to discuss the challenges the program has faced during Year 2, along with recommendations for Year 3.

Successes

The Marigold Program's most notable successes during the second year of operation fell into three broad categories: the referral process, staff competency, and providing necessary services to an underserved population. Each of these categories is discussed in turn below.

Referral Process

Several program successes can be identified that relate to Marigold's referral process: the increased number of referrals during Year 2, the increased number of referrals from schools, and the rapid response time between referral and intake session.

Increased referrals: One of Marigold staff's biggest struggles during the first year of operation was generating an adequate number of referrals. Referrals increased markedly during the second year of operation; the program received 97 referrals during the second year, up from 40 referrals during the first year. As a result, the therapists carried full caseloads by the spring of 2003. The program even had to briefly place several families on a waiting list during the spring because all counselors were at their maximum caseload.

The number of referring agencies grew during Year 2 as well; during Year 1 nine agencies made referrals to Marigold, and during Year 2 more than fifteen agencies made referrals. Increasing the pool of referring agencies provides Marigold with a stronger referral base; should referrals decrease from one source in the future, Marigold will continue to have a number of other referring agencies to draw upon.

While the increased referrals may be explained, in part, by the cuts in publicly funded programs that resulted from Oregon's 2003 budget crisis, the increase also is attributable to the program's continued publicity and outreach efforts. Budget cuts alone would not have resulted in increased referrals if the referring agencies had not been primed to refer families to Marigold.

Increased referrals from schools: In addition to the overall increase in referrals during Year 2, the program saw a marked increase in the number of referrals from schools (seven during Year 1 and 15 during Year 2). During Year 1, program staff identified making connections in the schools as one of their biggest challenges, and stated they would increase these efforts in Year 2. The referral data indicate that these efforts paid off in the form of increased referrals from schools throughout the county. Indeed, during Year 2, schools were by far the largest source of referrals to the program, accounting for one-fifth of all referrals.

Rapid scheduling of intake appointments: As discussed in Chapter 2, after a family is referred to the program, Marigold staff scheduled an intake assessment, or "zero session" in order to complete the JCP screen and the required FFT assessment instruments. A third of the zero sessions took place on the *same day* as the referral, and over one half took place within four days of the referral. The speed

with which Marigold staff scheduled the zero sessions is a reflection of their flexibility and dedication to serving the families of Umatilla County.

Staff Competency

Another success of the Marigold program is the highly competent and respected program staff. Interview respondents were unanimous in their praise for Marigold staff. The staff members were described as professional, competent, and approachable. Program staff, and particularly the program director, has gained the recognition of the national FFT headquarters.

Providing necessary services for an underserved population

Staff and key stakeholders alike believed that one of the biggest strengths of the Marigold program was that it offered a much-needed service for Umatilla County families. No other program in the county offers family-based therapy for girls, and respondents all agreed that such a service was desperately needed. Furthermore, respondents indicated that Marigold was far more accessible to families than other services. The program's ability to provide therapy sessions in the home and during evening and weekend hours is unique; other services for Umatilla County families do not often offer flexible hours and home-based services. During Year 2, Marigold expanded its services to reach a small number of boys and their families, thus responding to the need for, and the lack of, family therapy for at-risk boys in Umatilla County.

Challenges & Recommendations

The challenges faced by Marigold during Year 2 fit into two broad categories: public relations and data management. The challenges encountered in each of these areas are discussed below, along with recommendations for Year 3.

Public Relations

Several of the challenges faced by Marigold this past year can be categorized as relating to public relations: a lack of clarity around the purpose, scope, and limitations of FFT, a frustration among referral sources about the type and extent of communication between Marigold staff and referring agencies, and the challenge of making connections with the Native American community.

Lack of clarity in the purpose, scope, and limitations of FFT

While many interview respondents were knowledgeable about the FFT model used by Marigold, several had erroneous ideas of what the program provides. Even those respondents who knew that Marigold used the FFT model presented a lack of clarity around the scope and limitations of the FFT model. Staff members themselves pointed out that referring agencies and other community members may have unrealistically high expectations for what Marigold can or should accomplish with families. Staff members believe they may have unwittingly contributed to these expectations during their public relation and education campaign during Year 1.

Furthermore, the philosophy and goals of the FFT model may be contrary to the goals of other service providers, thus causing confusion over what the Marigold program can, and should, provide for the family. Some respondents also had concerns about whether the FFT model is appropriate for higher risk youth and their families. Youth may need multiple services in addition to family therapy, and therefore the FFT model, which prefers that families *not* be engaged in other services concurrently, may not be an appropriate model for these youth.

Recommendation #1: As staff members have become more versed in the FFT model they are more cognizant of what types of changes and progress it is realistic to expect from a family as a result of a 12-week course of FFT. Marigold's public relations efforts during Year 3 should be sure to describe the FFT model and philosophy along with the type and extent of family change that is realistic to expect. Furthermore, the material should clearly state whether high risk youth and families needing concurrent services are appropriate referrals.

Recommendation #2: Marigold should consider creating some innovative public relations materials. One possibility would be the creation of a short video that introduces Homestead and the Marigold program and describes the FFT model and the types of families that are appropriate for services. One interview respondent mentioned how useful it would be to have such a video to show at staff trainings and ongoing staff meetings.

Referring agencies' desire for more information about families served

While some interview respondents stated that they received communication from Marigold staff about whether or not families they referred enroll in Marigold services, many other respondents stated that they had not always received this feedback. Furthermore, respondents expressed the desire to have more communication with Marigold staff than just the initial phone call stating whether the family enrolled in Marigold's services. Respondents expressed an interest to hear from Marigold staff about whether families complete the program or not, families' progress, and what families accomplish from the FFT intervention. However, Marigold staff explained that the FFT model promotes limited contact between referral sources and therapists.

Recommendation #3: Marigold staff should clarify with referring agencies the extent of information they can provide about the families receiving services at Marigold.

Recommendation #4: If there are types of information that Marigold does agree to provide to referring agencies, Marigold may wish to create a standardized form that therapists could complete, either at the end of therapy or at some other pre-determined point, that would provide referring agencies with information about the family's progress. This form could then be completed for all families that sign a release of information form, whether families successfully complete FFT or drop out prior to completion.

Building a connection with the Native American community

One challenge identified by both Marigold staff and interview respondents was establishing a relationship with, and serving families from, the Native American community. Pendleton is located immediately adjacent to the Confederated Tribes of the Umatilla Indian Reservation. Despite the geographical proximity, barriers have prevented Marigold from successfully providing services to Native American families. Some interview respondents explained that Native American service providers prefer not to make referrals outside the reservation. Marigold staff members stated that they do not have connections with Native American referral sources. As described in Chapter 4, Marigold attempted to provide services to several Native American families, but has had difficulty engaging these families into the program. Marigold staff questioned whether members of the Native American community might be unreceptive to their services, and there was a perception on the part of the Native American community that Marigold was not open to providing services to Native American families.

Recommendation #5: In order for Marigold to have an increased number of referrals for Native American families, the program staff must establish themselves as culturally competent. A first step

toward achieving this goal may be to begin open communication with one or two representatives of the Native American community in order to determine what would make Native American service providers comfortable enough to make referrals to Marigold. Opening this dialogue with a handful of people may be a tangible first step for Marigold staff.

Data Management

Several challenges faced by the Marigold program can be categorized as data management issues, including the challenges they have faced with FFT's data system, incomplete documentation about families who do *not* enroll in Marigold's services, and the low number of families with matching intake and exit assessments.

Challenges with the CSS

As described in the Year 1 Evaluation report, Marigold staff members struggled with the customized database provided by FFT (called the Client Services System, or CSS) during the first year of program operation. This Access-based database had multiple glitches and problems that resulted in duplicate entries, disappearing data, and other related problems. In the spring of 2003, FFT converted to a Web-based database and transferred all of Marigold's data over to the new system. One advantage of the Web-based CSS is that the program director could access the case notes and assessments for all Marigold clients, which aided her with staff and case supervision.

The evaluation team has noted, however, that the Web-based CSS does not include several data elements present in the original Access system. The following data were part of the background information on each client stored in the Access system: language spoken in the home; whether youth is attending school, school grade level, school type, grades, and whether client is in special education; and client and familial substance abuse history, including current usage and whether client and family members have been in treatment in the past. These data elements were included in this Year 2 report because a number of Year 2 clients received services at Marigold prior to the switch to the Web-based system. In future years, however, these data elements will not be available on the CSS.

Recommendation #6: NPC welcomes a discussion with Marigold staff about whether these data elements are crucial for reporting purposes. If Marigold staff members would like the evaluation to continue to report on these variables, NPC can work with Marigold to create an alternate way for recording and transferring these data to NPC. Alternately, NPC also would be willing to enter into discussions with FFT about the feasibility of adding these variables to the Web-based CSS.

Incomplete documentation of the referral and eligibility process

A number of families were referred to Marigold, but for a variety of reasons many did not enroll in services. Some of these families took part in a zero session but then did not progress into services, and other families did not ever take part in a zero session; in Year 2 Marigold had 97 referrals, 58 families took part in a zero session, and 30 engaged in services. Marigold staff members have developed a system for tracking referrals, and NPC helped Marigold create and use a spreadsheet for recording JCP Risk Screen scores. However, these two systems did not provide the complete information necessary to determine why families did not attend a zero session or to determine why some families who had zero sessions did not engage in services. Because the number of people eventually enrolling in services was far smaller than the number who complete the JCP screen and the number who were referred, it appears that there are factors other than the age and JCP eligibility criteria that determine whether families were enrolled in Marigold's services. It would be useful to document these criteria, as well as to distinguish

between those families that are accepted into Marigold's service but refuse, from those families not accepted into services.

Recommendation # 7: Marigold may wish to keep more complete documentation on those families who do *not* enroll in services. NPC is willing to work with Marigold staff to determine the most efficient way of documenting the information necessary to track why some families do not enroll in services.

Lack of matching pre- and post-assessment score data

As described in Chapter 5, families completed FFT assessments at program intake and exit. During the second year of program operation, Marigold staff members increased efforts to ensure that families completed the exit paperwork. However, program data indicate that there are few families for whom the intake and exit paperwork was complete *for the same family members*. For example, for one family there were intake assessments for the mother and the youth, and exit assessments for the father and youth. For data analysis purposes, it is necessary to match intake and exit assessments for each person in order to measure change over time.

Recommendation #8: In addition to ensuring that family members complete the exit assessments, Marigold staff should be sure to administer the intake assessments to family members who may join in the counseling process after the zero session.

Conclusion

While it is always possible to identify areas of improvement for program performance, as outlined above, Marigold continues to be a solidly managed program that provides much needed services to Umatilla County families. At the close of Year 2, referrals remained high, therapists carried full caseloads, the program provided timely intake sessions, and staff members utilized case management in a manner complimentary to the FFT model. During Marigold's second year of operation, program staff became more proficient in the FFT model and have been recognized by the FFT as having particularly high adherence to the model and staff members continued to excel in their work with at-risk youth and families.

Appendix A: Average Intake Assessment Scores

Table 10. Average OQ45.2 Scores for Year 2

Subscale	Adolescent (N=24)	Mother (N=23)	Father (N=12)
Symptom Distress	45*	36*	28
Interpersonal Relations	15*	23*	13
Social Role	15*	9	10

* Scores fall in the clinical range.

Table 11. Average OQ45.2 Scores for All Marigold Families

Subscale	Adolescent (N=50)	Mother (N=30)	Father (N=15)
Symptom Distress	40*	36*	32
Interpersonal Relations	15*	21*	14
Social Role	14*	10	11

* Scores fall in the clinical range.

Table 12. Average YOQ Scores for Year 2

Subscale	Mother (N=20)	Father (N=9)
Interpersonal Distress	26*	22*
Somatic	8*	6*
Interpersonal Relations	13	10
Social Problems	8*	6*
Behavioral Problems	16*	17*
Critical Items	9*	8*

* Scores fall in the clinical range.

Table 13. Average YOQ Scores for All Marigold Families

Subscale	Mother (N=42)	Father (N=20)
Interpersonal Distress	24*	22*
Somatic	7*	5
Interpersonal Relations	13	10
Social Problems	8*	8*
Behavioral Problems	15*	14*
Critical Items	7*	7*

* Scores fall in the clinical range.

Appendix B: Average Intake and Exit Assessment Scores⁶

Table 14. Average OQ45.2 Intake and Exit Scores

Subscale	Adolescent (N=16)		
	Pre	Post	Diff
Symptom Distress	41	35	6
Interpersonal Relations	14	15	-1
Social Role	14	13	1

* Negative numbers indicate change in the opposite direction as expected, or a higher average score at exit.

Table 15. Average FAM Intake and Exit Scores

Subscale	Adolescent (N=17)			Mother (N=13)			Father (N=10)		
	Pre	Post	Diff	Pre	Post	Diff	Pre	Post	Diff
Task Accomplishment	62	53	9 [^]	63	51	12 [^]	55	60	-5
Role Performance	60	52	8	61	58	3	54	57	-3
Communication	66	56	10 [^]	62	53	9 [^]	57	59	-2
Affective Expression	60	52	8	60	53	7 [^]	54	59	-5
Involvement	66	56	10 [^]	59	53	6 [^]	52	60	-8
Control	57	52	5	58	53	5	56	57	-1
Values and Norms	57	52	5	58	52	8 [^]	52	56	-4

[^] Statistically significant at .05

* Negative numbers indicate change in the opposite direction as expected, or a higher average score at exit.

⁶ These averages are based on family members with both intake and exit assessment scores.

Table 16. Average YOQ Intake and Exit Scores

Subscale	Mother (N=14)			Father (N=10)		
	Pre	Post	Diff	Pre	Post	Diff
Interpersonal Distress	26	19	7 [^]	21	15	6
Somatic	7	6	1	5	5	0
Interpersonal Relations	11	7	4 [^]	8	7	1
Social Problems	7	5	2	7	5	2
Behavioral Problems	15	12	3	11	9	2
Critical Items	7	5	2	5	5	0

[^] Statistically significant at .05

Appendix C: Percentage of Family Members in Clinical Range at Intake and Exit

Table 17. Percent of Family Members with OQ45.2 Scores in the Clinical Range

Subscale	Adolescent		Mother		Father	
	Pre (N=50)	Post (N=18)	Pre (N=30)	Post (N=14)	Pre (N=15)	Post (N=10)
Symptom Distress	60%	56%	47%	21%	27%	20%
Interpersonal Relations	50%	61%	53%	29%	33%	40%
Social Role	66%	56%	40%	7%	40%	10%

Table 18. Percent of Family Members Rating their Child in the Clinical Range on the YOQ

Subscale	Mother		Father	
	Pre (N=42)	Post (N=15)	Pre (N=20)	Post (N=10)
Interpersonal Distress	71%	53%	75%	40%
Somatic	69%	67%	50%	40%
Interpersonal Relations	0%	0%	0%	0%
Social Problems	83%	67%	90%	40%
Behavioral Problems	60%	53%	70%	40%
Critical Items	76%	33%	60%	60%

Table 19. Percentage of all Families Served with FAM Scores in Clinical Range

Subscale	Adolescent		Mother		Father	
	Pre (N=50)	Post (N=17)	Pre (N=44)	Post (N=14)	Pre (N=20)	Post (N=12)
Task Accomplishment	44%	35%	52%	14%	55%	33%
Role Performance	46%	24%	46%	43%	45%	42%
Communication	66%	41%	55%	29%	65%	50%
Affective Expression	54%	41%	41%	21%	45%	33%
Involvement	56%	35%	48%	36%	55%	50%
Control	40%	29%	52%	14%	60%	42%
Values and Norms	32%	24%	50%	21%	55%	25%

Averages include data from Year 1 and Year 2 family members with an intake, exit or both (intake and exit) score.