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An Evaluation of the Marigold Program, Umatilla County, Oregon

Year 3 Evaluation Report

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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 3 Evaluation Report highlights several findings.

- The program had a diversified referral base and a streamlined intake process.
- Despite a large number of referrals, the program's service delivery objective was not met.
- The program served more boys than anticipated.
- The program did not serve the Native American community.
- Dropouts hindered the program's ability to meet its completion objective.
- Families who completed Marigold services reported improvement on almost all domains of family functioning.
- Almost all youth who completed Marigold services were attending school or a vocational program after program completion.
- Youth who completed Marigold services exhibited a marked decrease in substance use.
- Youth with person and runaway prior referrals to the juvenile system had lower Marigold completion rates than youth with property, drug, curfew, other, or no prior referrals.
- Youth with prior referrals to the juvenile justice system who completed Marigold services were less likely to recidivate than youth with prior referrals who did not complete Marigold services.

During Marigold's third year of operation, the number of referrals increased to 115 compared to 97 in Year 2, and the number of service providers referring to Marigold also increased. The short length of time between the referral and the intake session illustrated Marigold's proficiency in receiving and processing referrals. However, many referred families did not engage in Marigold services, which resulted in fewer than anticipated numbers of families served during Year 3 (66 families were served, and the program objective was 100 families). Chapter 2 documents the referral process along with the stages at which families dropped out of the process.

Based on the demographics and presenting issues of the families served by Marigold, the program was reaching its target population. Some families dropped out of Marigold services during the course of therapy, and these dropouts hindered the program's ability to meet its completion objective (67% of families completed, and the program objective was 80%). Most dropouts occurred during the first phase of therapy, indicating these

families did not adequately engage in FFT. Chapter 3 describes the families served and documents program retention.

Marigold met its outcome objectives for families who completed therapy. Most family members reported improvements on multiple domains of family functioning, youth were in school at the time of program completion, youth decreased their substance use, and youth completing therapy were less likely to have subsequent juvenile justice involvement than those youth who did not complete therapy. Chapter 4 presents this outcome data.

Chapter 1: Description of the Program and the Outcome Evaluation

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 girls and their families. During the second year of operation, Marigold expanded its services to include boys.

Homestead has four main goals for the Marigold program. First, the program should increase individuals' coping and life management skills; improve parenting skills; help families achieve effective communication and functioning; and strengthen and stabilize the family. Second, youth who complete therapy will, hopefully, remain or re-engage in school or a vocational program. Third, fewer youth will be use alcohol and/or drugs after completing therapy. Fourth, with improved family relations and communication, participating youth would reduce their delinquency behavior, and, as a result, juvenile justice system referrals will be reduced. Appendix A provides a more detailed description of the Marigold Program.

Outcome Objectives

The Marigold Program has identified a set of core objectives for the program:

- Marigold will provide service to 100 families annually;
- Marigold's caseload will be no more than 15% boys;
- 80% of families served will complete therapy;
- 80% of those families completing therapy will show increased family functioning;
- 80% of youth completing therapy should be attending school or vocational programs at the close of therapy;
- Of youth completing therapy, 50% fewer will use substances at the end of therapy;
- No more than 20% of youth completing therapy should be in OYA placement 12-months after therapy; and
- Youth who complete therapy as well as all youth served should show a decrease in juvenile justice system involvement 6 and 12-months after therapy.

Appendix B includes a logic model that illustrates the link between program activities, objectives, and measurement plans.

Target Population

The Marigold program targets adolescent girls and boys between the ages of 11 and 18 who exhibit at least two risk factors on the Juvenile Crime Prevention Risk Screen Assessment. The program strives to keep at least 85% of their caseload for girls in order to maintain the focus on this population. Eligible youth must live in Umatilla County, ideally live at home, and have parents or guardians willing to participate in therapy, or, if not, at least have family members or guardians willing to participate and work toward reconciliation. Furthermore, eligible youth should not be at risk of imminent out-of-home placement and should not be involved in concurrent family treatment. Referrals to the program come directly from families as well as from agencies such as the Juvenile Services Division, middle and high schools, social service agencies, and mental health agencies.

Program Components

Below we describe the components of the Marigold program, including Functional Family Therapy, program staff and case management.

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 improve." [1] 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.

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[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.

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 Staff

Marigold staff consists of the program director/clinical supervisor, two therapists, and a case manager. Each therapist has a maximum caseload of 12 families, and the therapists' caseloads are often near, or at, capacity. The program director also serves as a therapist with a reduced caseload (between 2 and 3 families). The program director also is a certified FFT supervisor, and as such, provides weekly clinical supervision to the two Marigold therapists.

Case Management

The Marigold program includes a case management component. The case manager helps families access needed services by providing appropriate referrals and helps families navigate the oftentimes confusing public support and social service systems. The case manager works with families who request help with a variety of needs including, but not limited to, educational and vocational training and job searches; basic assistance such as food, shelter, and clothing; transportation assistance; and childcare assistance. The case manager introduces herself to the families early in the therapy process but typically does not start working with families until the last phase of the FFT model. As families transition into the final FFT phase, the therapist begins discussing the families' functioning after they leave the Marigold program. At this point, the therapists determine, with families, whether they have any needs with which the case manager can help.

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 challenges and successes during the first year of operation. During Year 2, evaluation activities included a continued process evaluation as well as limited outcome monitoring. The Year 2 report was released in September 2003. During the third year of the project, the focus of the evaluation activities shifted from the process evaluation to outcome monitoring.

The primary outcomes of interest for the evaluation are family functioning, school attendance, substance use, and juvenile justice involvement. NPC gathers referral information from a referral tracking form developed for this evaluation and gathers intake and demographic information through the Client Services System (CSS) mandated by FFT. To measure family functioning the evaluation relies upon the Client Outcome Measure (COM). FFT requires that all clients complete this instrument at the time of program exit. 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 school attendance and substance abuse. In addition, therapists complete a similar measure for each family called the Therapist Outcome Measure (TOM).

To gather information about longer-term outcomes, NPC conducted follow-up telephone surveys with youth and mothers (modeled on the COM instrument) three and 12 months after program exit. These telephone surveys provide valuable information about family functioning and youth behaviors (substance use and school attendance) for a period of time *after* the completion of therapy. However, not all youth and parents were available for a follow-up telephone interview three months after their program exit. Interviewers were able to contact and interview approximately half of those who Marigold served. To measure juvenile justice system involvement, juvenile justice data was gathered from Oregon's Juvenile Justice Information System (JJIS). NPC Research gathered data for each participant on involvement with the juvenile justice system in the 12 months prior to Marigold participation as well as in the 12 months after completion of the Marigold program. However, for many youth who Marigold has served, a full 12 months has not yet elapsed. This is especially true for Year 3 families.

Year 3 Evaluation Report

The remainder of this report documents NPC's evaluation of Marigold's third 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 3 (families served between July 1, 2003, and June 30, 2004), 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, presenting issues, and retention. Chapter 4 documents outcomes at the time of program exit as well as longer-term family functioning, substance use, and juvenile justice outcomes. The final chapter of the report, Chapter 5, summarizes the evaluations findings and presents NPC's recommendations for Year 4.

Chapter 2: Referral Process

This chapter provides a description of the referral process, referral sources, demographics of the youth referred to Marigold, program eligibility (including the results of the Juvenile Crime Prevention risk assessment tool) and program engagement.

During Year 3, the Marigold case manager continued to be the primary recipient of all referrals. Typically, the Marigold case manager received a telephone call from a referring agency and captured the family's contact information. The case manager then contacted the family directly to assess their program eligibility. If the family met the preliminary program criteria (appropriate age, the youth was "at-risk," and the family lived within Marigold's service area), a "zero" session was scheduled. At the "zero" session, the case manager met with the family (usually at their home) and the family completed initial program paperwork.

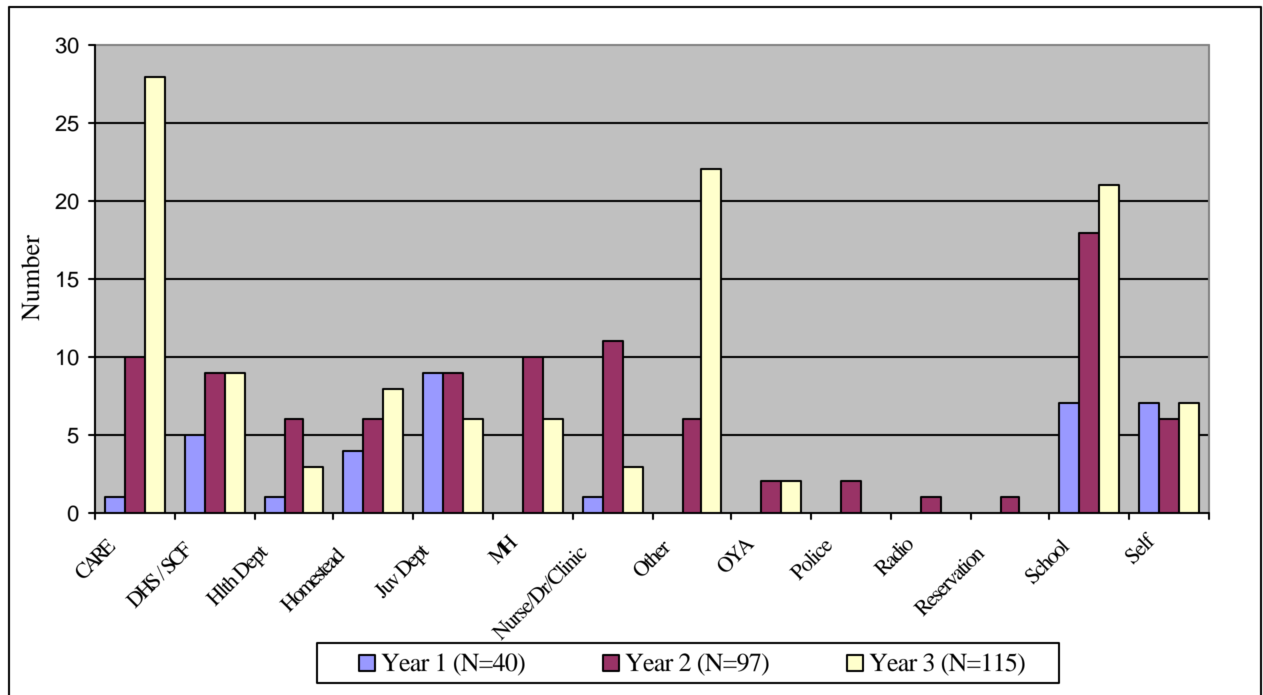
A new tool was implemented during the second half of Year 3 to document each step of the referral process. For each referral, a Referral Tracking Form captured the date of the referral, the referral source, background family information, the youth's eligibility prior to the Juvenile Crime Prevention (JCP) risk assessment, the results of the JCP risk assessment, and the date of the "zero" session. This new tool enabled evaluators to track and detail the referral process in a way that was not previously available.

Number of Referrals and Referral Sources

During Year 3, Marigold received 115 unique referrals[2] from more than 17 different sources. Marigold received an average of 9.6 referrals each month with slightly fewer referrals in June (n=4) and slightly more referrals in February (n=16). Figure 1 illustrates the quantity of referrals from Year 1 to Year 3 by referral source. During Year 3, Marigold received an increase in referrals from CARE (a school-based resource program), Homestead, schools, and other sources.[3] However, during Year 3 Marigold experienced decreased referrals (compared to Year 2) from the Health Department, the Juvenile Department, Mental Health, and those in the medical profession (nurses, doctors, and clinics).

[2] Five youth were referred twice during Year 3.
[3] Other referral sources included Commission on Children and Families, Child Welfare, Sandstone Middle School, Tanya's House (a runaway shelter), Horizon (an after school tutoring program), Domestic Violence Services, Special Education Services (ESD), and a psychologist.

Figure 1. Referrals Sources from Year 1 to Year 3



Demographics of Youth Referred

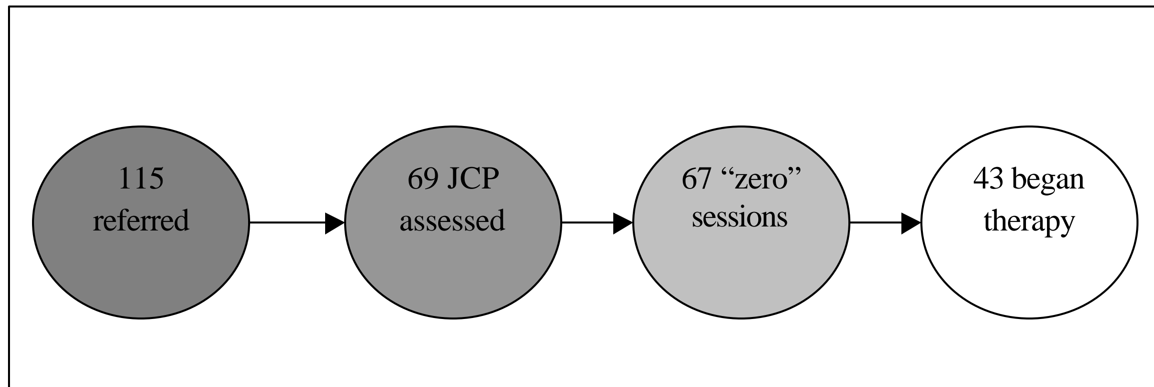
During Year 3, Marigold received almost twice as many referrals for girls (66%) than for boys (34%). The average age of youth referred to Marigold was 13 years old. The majority of youth referred (90%) were White (non Hispanics). Seven percent of those referred were Hispanic and one percent was African American (two percent had missing ethnicity data). These proportions are similar to the ethnicity proportions of Umatilla County (82% white, 16% Hispanic, and one percent African American[4]). However, Umatilla County is 3% Native American and during Year 3 Marigold received no Native American referrals. A challenge for the Marigold program, noted in the Year 2 Evaluation Report, was the lack of established relationships with referral sources in the Native American community. Although Marigold staff made efforts to form positive connections with referral sources in the Native American community during Year 3, referrals from this community were not forthcoming.

[4] Source: U.S. Census Bureau www.quickfacts.census.gov. Note: Due to some respondents reporting multiple races, percentages sum to slightly more than 100%.

Stages of the Referral Process

Of the 115 unique cases referred to Marigold during Year 3, 69 completed a JCP risk assessment, 67 had a "zero" session (at which time families completed initial program paperwork), and 43 had at least one FFT session. [5] (See Figure 2.)

Figure 2. Number of Families completing the Referral Process



Marigold employed the JCP risk assessment to screen referred youth for eligibility. The JCP risk assessment tool contains "risk" and "protective" indicators in five different domains (school, peer relationships, behavior, family functioning, and substance use). Of the 69 youth with JCP risk data, the total number of risk factors ranged from 1 to 23, with youth averaging 9.6 risk factors. [6] Seventy-four percent of the youth with JCP risk data had a least one risk indicator in the School Domain; 82% had one or more risk factors in the Peer Relationships Domain; 80% had risk indicator(s) in the Behavioral Issues Domain; all (100%) were at risk in the Family Functioning Domain; and 69% had at least one risk factor in the Substance Abuse Domain.

Documentation from the newly implemented referral tool illuminated some of the reasons why 48 (42%) referred families did not participate in a "zero" session. For instance, eight referred families declined program participation; five referred families wanted another type of service (such as individual therapy or a girl's residential home); four referred youth did not meet the minimum age requirement (they were under 11 years old); three referred families lived or moved out the Marigold's service area; and three referred families were not able to be reached (see Table 1 below). However, 67 (58%) families remained engaged in the referral process through to a "zero" session. For those families, the number of days elapsing between the referral date and the "zero" session date ranged from 0 to 47, with a median of six days.

[5] These 43 families are a subset of the total number of families served during Year 3. While not included in this chapter, an additional number of families began services in Year 2 and continued to receive service in Year 3.

[6] Although the Marigold program typically requires the presence of at least two JCP risk indicators, in one case, program services were extended to a family with multiple issues, all of which were contained in a single risk indicator.

Table 1. Reasons Families Failed to Participate in a "Zero" Session

Reason	Number of Families
Family declined/refused participation	8
Family wanted another type of service	5
Youth did not meet Marigold's age requirements	4
Marigold staff couldn't connect/reach family	3
Family moved or lived out of service location	3

Note: Twenty-five families were referred to Marigold prior to the implementation of the referral tracking form; there is no documentation about why these families dropped out of the referral process.

Twenty-four families completed a "zero" session yet failed to engage in the Marigold program. Thirteen of these 24 cases were assigned a therapist but these families never began therapy. Of these 13 cases assigned to a therapist, documentation was available to illuminate the reasons why five families failed to engage in therapy. In two families, the youth ran away from home; in another two families, Marigold staff were unable to make contact with the family; and one family lost their housing (and became homeless). For three of these families, the Marigold case manager provided immediate case management services to the family (including housing assistance, summer school enrollment and nursing home placement). However, for 19 of these 24 cases, it is unclear as to why families who completed a "zero" session failed to engage in Marigold services.

Program Engagement

Analyses were conducted on various groups to determine if there was a pattern of which youth were more or less likely to engage in the Marigold program. Of the White (non-Hispanic) population of referred youth, 37% engaged in Marigold. Half (50%) of the Hispanic referred youth engaged. The only African American youth referred engaged. A third of the youth (n=6) for whom Spanish was their primary language engaged in the Marigold program. [7]

Although not substantially different, youth who engaged in the Marigold program (those who had at least one FFT session) on average had slightly fewer JCP risk factors (9.5) compared to those who did not engage (9.8). This was true across domains except for in the Family Functioning Domain. In the Family Functioning Domain, youth who engaged in Marigold had a slightly higher average number of number of risk factors (3.2) compared to those who did not engage (3.0).

Summary

The Marigold referral process operated in a similar fashion as in Year 2, with the exception of a newly implemented Referral Tracking Form. Marigold received a greater number of referrals in Year 3 compared to Year 2 (115 verses 97) from more than 17

[7] Results need to be interpreted with extreme caution when group sizes are small.

different referral sources. Youth referred mirrored the ethnicities of Umatilla County youth with the exception of Native Americans. Although 115 youth were referred to Marigold, only 37% (43) engaged (by receiving at least one FFT session). Although the new Referral Tracking Form conveyed the reasons why families disengaged throughout the referral process prior to the “zero” session, it is not clear why some families (n=19) completed a “zero” session but did not begin services with a therapist.

Chapter 3: Families Served and Retention

Objective: 100 families will be served. *Output: 66 families were served.*

Marigold provided therapy (defined as a family having at least one Engagement and Motivation Phase session) to 66 families during Year 3.[8] An additional three families received immediate case management services but did not begin counseling with a therapist. While the program did not serve 100 individuals, Marigold did receive more than 100 referrals during Year 3, but as discussed in Chapter 2, some referred families declined to participate and some were not eligible for Marigold services. In this chapter we describe the demographics and presenting issues of the families served (n=66) and discuss retention and dropout rates for these families.

Demographics of Families Served

Objective: 85% of clients will be girls. *Output: 68% of clients served were girls.*

During Year 3, 68% of the clients served by Marigold were girls. The proportion of girls served mirrors the proportion of girls received referred to the program. However, this falls short of the objective of 85%. Marigold's protocol during Year 3 was to focus on keeping therapists' caseloads full rather holding an available therapy slot for a girl.

The average age of clients served was 15, with a range of 11 to 18. Ethnicity data were available for 61 of the 66 families, and the majority of this group was Caucasian (85%), and smaller numbers of families served were Hispanic (8%) or African-American (3%). One family served was Native American (this family began services in Year 2 and continued services into Year 3; this was not a new referral during Year 3). Information about parental marital status was available for 47 families; 49% of the parents in these families were married; 38% of these families were separated, divorced, or widowed; and 13% were single.

Data on whether a family's participation was mandated (e.g. by the Juvenile Department as a condition of probation) was available for 52 families, and 27% of these families were mandated to participate in Marigold services.

[8] Some of these families were newly enrolled in Year 3 and some began services in Year 2 but continued to participate in therapy during Year 3.

Assessment Scores and Presenting Issues

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. In addition to these assessment measures, therapists recorded detailed case notes after the first therapy session describing the families' presenting issues.

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). Intake scores on the OQ45.2 indicated that a majority of adolescents scored themselves in the clinical range on the Interpersonal Relations and Social Role subscales, while a majority of mothers rated their children in the clinical range on the Symptom Distress subscale and a majority of fathers rated their children in the clinical range on the Interpersonal Relations subscale (see Table 2 below).

Table 2. Percentage of Year 3 Families with OQ45.2 Scores in Clinical Range

Subscale	Adolescent (N=59)	Mother (N=58)	Father (N=44)
Symptom Distress	49%	52%	48%
Interpersonal Relations	54%	48%	55%
Social Role	63%	43%	46%

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

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 3 illustrates, more than 40% of youth, mothers, and fathers receiving services from Marigold in Year 3 fell in the clinical range on the Task Accomplishment subscale (indicating they had problems with basic tasks or identifying solutions to problems). Furthermore, nearly 30% or more of youth, mothers, and fathers scored in the clinical range on the remaining six subscales: the Communication subscale, indicating problems with communication or a lack of understanding of other family members; the Affective Expression subscale, indicating they either lacked sufficient expression or had overly emotional responses; the Involvement subscale, indicating insufficient family involvement and a lack of autonomy or narcissistic involvement; the Control subscale, indicating power struggles, use of control to shame, and lack of ability to adjust to changing life demands; and the Values and Norms subscale, indicating disjoined values systems, resulting in family tension and confusion.

Table 3. Percentage of Year 3 Families with FAM Scores in Clinical Range

Subscale	Adolescent (N=59)	Mother (N=58)	Father (N=43)
Task Accomplishment	42%	45%	49%
Role Performance	34%	36%	40%
Communication	37%	41%	49%
Affective Expression	36%	43%	42%
Involvement	39%	38%	44%
Control	27%	40%	49%
Values and Norms	34%	31%	38%

Youth Outcome Questionnaire (YOQ)

The Youth Outcome Questionnaire (YOQ) is a measure of adolescent behavior. Youth, mothers and fathers completed a YOQ at intake. Intake scores on the YOQ indicate that a majority of youth, mothers, and fathers scored in the clinical range on all subscales *except* the Interpersonal Relations subscale, as illustrated in Table 4. Thus, a majority of family members rated the adolescents in the clinical range on the Interpersonal Distress subscale, which measures emotional distress; the Somatic subscale, which measures physical problems; the Social Problems subscale, which measures aggression and delinquency; the Behavioral Problems subscale, which measures inattention, hyperactivity, impulsivity, concentration, and ability to handle frustration; and the Critical Items subscale, which measures delusions, suicide, mania, and eating disorders.

Table 4. Percentage of Year 3 Families with YOQ Scores in Clinical Range

Subscale	Client (N=49)	Mother (N=56)	Father (N=42)
Interpersonal Distress	78%	75%	83%
Somatic	65%	59%	56%
Interpersonal Relations	29%	14%	34%
Social Problems	76%	77%	83%
Behavioral Problems	76%	75%	76%
Critical Items	71%	59%	78%

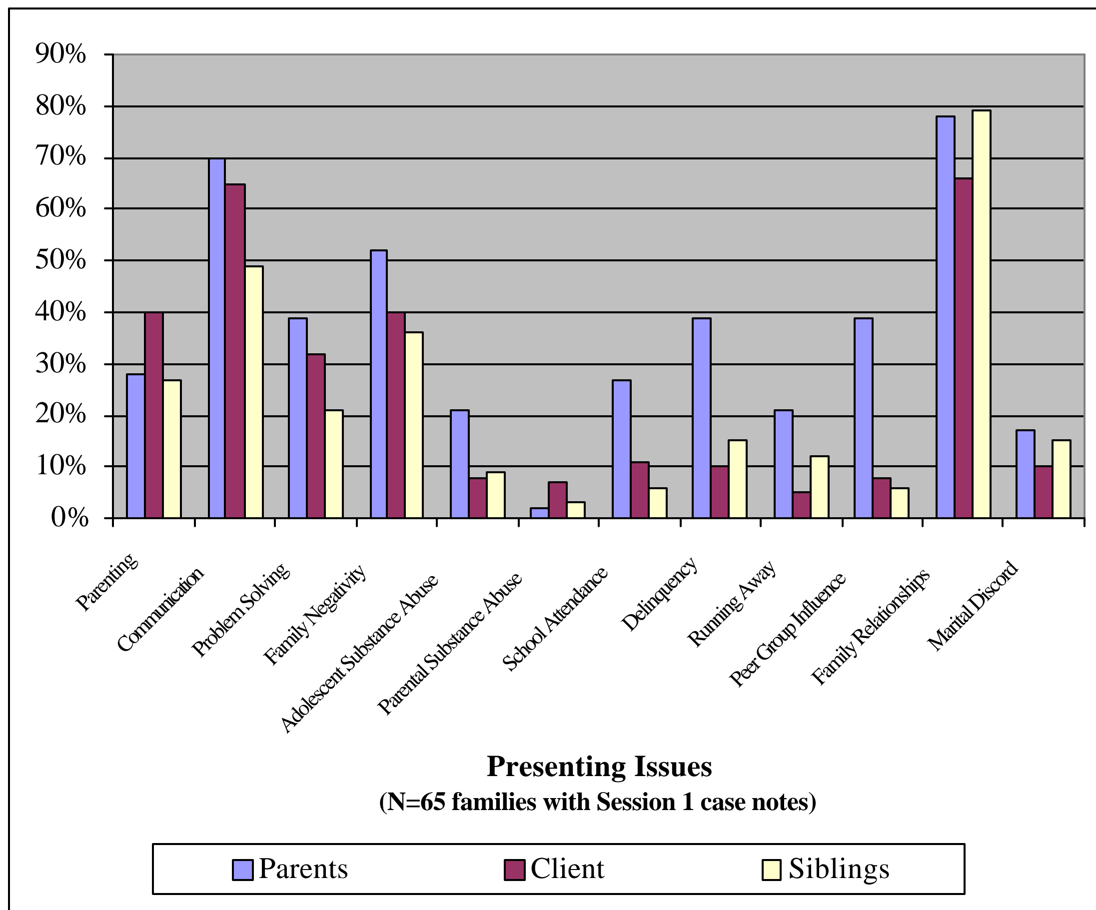
Note: Subscales with 50% or more in clinical range are shaded gray.

Presenting Issues

After each therapy session, Marigold therapists recorded notes; the notes from the first therapy session include information regarding the families' presenting issues. Therapists recorded whether each family member (father, mother, identified adolescent, and siblings) identified any one of a series of issues as problem areas for the family. In addition, therapists recorded a narrative description of each family's situation and challenges.

Most families described problems with family relationships and communication. Family relationships, communication, and negativity were most often described as the issues facing Marigold families. Parents were more likely than the clients and clients' siblings to identify adolescent substance abuse, school attendance, delinquency, running away, and peer group influence as problems for the family. Clients and their siblings, on the other hand, were more likely than parents to identify parental substance abuse as a problem for the family. Figure 3 illustrates the presenting issues described by the families.

Figure 3. Presenting Issues for Families Served in Year 3



Therapists' narrative descriptions of the families' presenting issues mirrored and expanded upon the data illustrated above. Many families were described as struggling with anger, on the part of the adolescent, the parent, or both, in addition to a lack of trust between family members, disrespect and insubordination among family members, control issues, and fighting. Many families were struggling with life stressors, including chronic illnesses, deaths of loved ones, divorced or blended families, financial concerns, domestic violence, and child abuse.

Retention

Objective: 80% of families served will complete therapy.
Output: 67% of families served completed therapy.

Data on cases that closed during Year 3 (n=46) indicate that for those families who began services (defined as having at least one Engagement and Motivation Phase session), 67% completed therapy (defined as having a termination status other than dropout and at least one Generalization Phase session).[9] As illustrated in Table 5, families who completed therapy had an average of 11 sessions, with an average of four Engagement and Motivation Phase sessions, an average of four Behavior Change Phase sessions, and an average of three Generalization Phase sessions.

Table 5. Number of Therapy Sessions for Year 3 Completed Cases

	Engagement & Motivation	Behavior Change	Generalization	Total
Average number of sessions	4	4	3	11
Minimum number of sessions	1	1	1	6
Maximum number of sessions	6	11	7	18

Thirteen Year 3 families who attended at least the first therapy session dropped out at some point later during therapy. Three quarters of these dropouts occurred during Phase 1 and one quarter occurred during Phase 2. Figure 4 illustrates when dropouts occurred.

[9] A total of 46 cases closed during Year 3. However, a termination status code was missing for 7 cases, and therefore, this analysis is based on a sample size of 39 cases.

Figure 4a. Dropout Phase for Families Served in Year 3

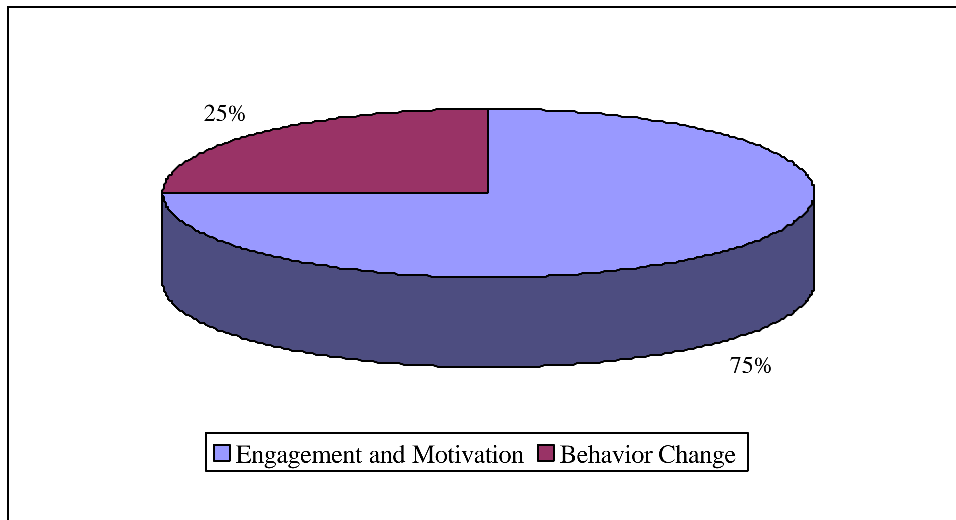
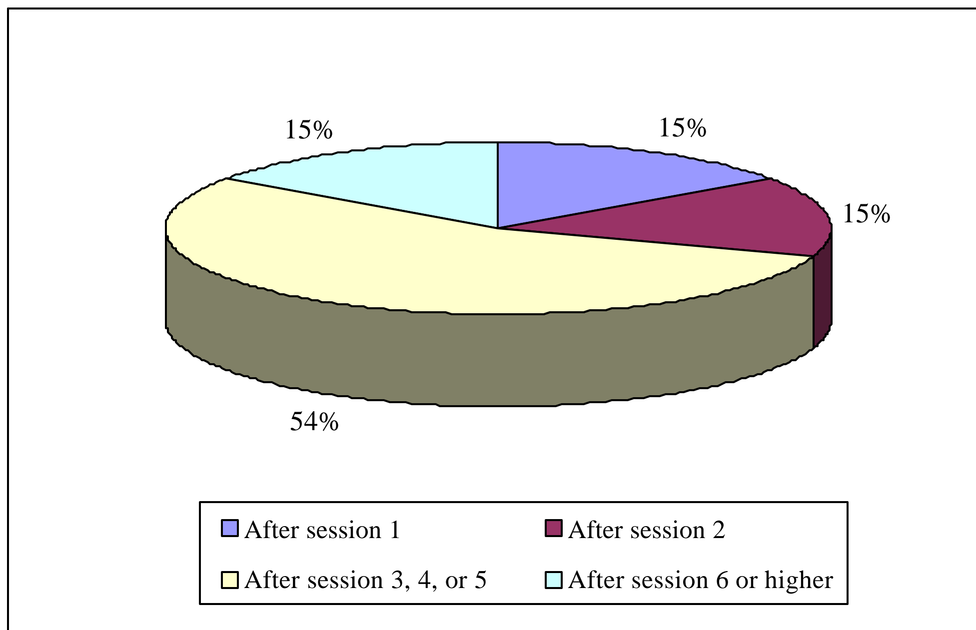


Figure 4b. Dropout Session for Families Served in Year 3



While some dropouts occurred due to the family moving out of the county (three cases, or 23%), most dropouts (ten cases, or 77%) occurred after repeated contact by Marigold staff. The lower than expected completion rate for families can be explained by these dropout data, which suggest that Marigold faces challenges engaging families early in therapy.

Summary

Marigold served 66 families during Year 3, approximately two-thirds of whom were families with girls. The assessment scores and presenting issues of these families indicate that many were struggling with family relationships, communication, negativity, and parenting, and many families were dealing with life stressors such as loss, illness, financial insecurity, violence, and blended family structures. During Year 3, 67% of families served completed therapy, a proportion slightly lower than the anticipated 80%. Families who dropped out of services after initially engaging influenced the completion rate: thirteen families dropped out of services, and ten of these dropouts occurred during the Engagement and Motivation Phase. While three of these dropouts were due to families moving outside the service area, the remaining ten dropouts occurred despite repeated contact attempts by Marigold staff.

Chapter 4: Outcomes for Youth and Families

This chapter reports on the outcomes for youth and families at the time of program exit, as well as subsequent to program exit. Reported outcomes include family functioning, school attendance, substance use, and juvenile justice system involvement. Data on outcomes at the time of program exit and three months post program exit are reported for completing Year 3 families (n=26), while data on longer-term juvenile justice outcomes are reported on all Marigold families served since program inception (n=95). [10]

Family Functioning

Objective: 80% of families completing therapy should show improvement in each of the six COM domains.

Outcome at program exit: At exit, more than 80% of Year 3 youth and fathers completing therapy improved in four of the six COM domains, and more than 80% of mothers reported improvement in all six of the COM domains.

Outcome three months after program exit: After three months, more than 80% of Year 3 families completing therapy showed improvement in all but one of the COM domains, according to the youth, and in all COM domains, according to the mother.

Each family member completed the Client Outcome Measure (COM), a required FFT measurement tool, during the last therapy session and again (through follow-up telephone interviews with youth and mothers) three months after program exit. This measure asked youth and their parents to rate family change in six different domains: overall level of family change, change in communication skills, change in adolescent behavior, change in parenting, change in parental supervision, and change in family conflict.

At exit, 80% or more of completing Year 3 youth and fathers reported improvement in four of the COM domains: overall family change, change in communication skills, change in adolescent behavior, and change in family conflict. The percent of completing youth and fathers reporting improvement in the remaining two domains (improvement in parenting skills and parental supervision) was between 70% and 79%. More than 80% of completing Year 3 mothers, however, rated favorable change in all six COM domains. Table 6 lists the percent of family members indicating positive change in the six COM domains.

[10] Juvenile justice data were collected in May 2004. As of May 2004, many Year 3 families had not yet been exited from the Marigold program for a full 6 or 12 month time period, and therefore data are reported for Year 1, Year 2, and a subset of Year 3 clients.

Table 6. Percent of Year 3 Completing Families Indicating Improvement on the COM at Exit

COM Domain	Adolescent (n=19)	Mother (n=20)	Father (n=10)
Overall Family Change	95%	100%	100%
Change in Communication Skills	84%	100%	100%
Change in Adolescent Behavior	84%	95%	100%
Change in Parenting Skills	74%	95%	70%
Change in Parental Supervision	79%	85%	70%
Change in Conflict	89%	90%	92%

Note: Items with 80% or more indicating positive change are shaded gray.

After three months from their Marigold program exit, 80% or more completing Year 3 youth reported favorable change in five of the six COM domains. The only domain in which less than 80% of youth reported favorable change was the adolescent behavior change domain. Eighty percent or more of completing Year 3 mothers rated favorable change in all six COM domains. Table 7 lists the percent of youth and mothers indicating positive change in the six COM domains.

Table 7. Percent of Year 3 Completing Families Indicating Improvement on the COM Three Months after Program Exit

COM Domain	Adolescent (n=12)	Mother (n=14)
Overall Family Change	100%	85% (n=13)
Change in Communication Skills	83%	86%
Change in Adolescent Behavior	67%	86%
Change in Parenting Skills	92%	86%
Change in Parental Supervision	92%	86%
Change in Conflict	92%	86%

Note: Items with 80% or more indicating positive change are shaded gray.

School Attendance

Objective: 80% of youth completing therapy should be attending school or a vocational program at the close of therapy.

Outcome at program exit: 92% of Year 3 youth completing therapy were attending school or a vocational program at the close of therapy.

Outcome three months after program exit: 93% of Year 3 youth completing therapy were attending school or a vocational program three months after therapy.

The COM completed at program exit and completed again via telephone interviews three months after program exit captured school attendance data. Data on school attendance at the close of therapy were available for 25 of the 26 Year 3 completed cases. At the close of therapy, 23 (92%) youth were attending school or a vocational program. Data on school attendance three months after therapy were available for 14 of the 26 Year 3 completed cases (the remaining youth had not yet reached their 3-month follow-up point or could not be reached for interviews). Three months after therapy, 13 out of 14 youth (93%) were attending school.

Substance Use

Objective: Of youth completing therapy, 50% fewer will use substances at the end of therapy.

Outcome at program exit: There was a 72% decrease in alcohol use and an 81% decrease in drug use for Year 3 youth who completed therapy.

Evaluators asked the Marigold case manager and counselors to provide a report of youth substance use at the time of program intake. Additionally, the youth and parent COMs captured the youth's substance use at both the time of program exit and again three months later.

According to Marigold staff, four of the youth who completed therapy in Year 3 used alcohol and six used drugs at the time of program intake. At program exit, 23 youth and parents had completed an exiting COM and their reports of drug and alcohol use were identical: one youth was using alcohol and drugs at the time of program exit. Table 8 displays these data along with the calculated percent change.

Table 8. Substance Use Among Year 3 Completing Youth at Program Exit

	Number of Youth At Intake (n=26)	Number of Youth At Exit (n=23)	Percent Change
Alcohol Use	4	1	-72%
Drug Use	6	1	-81%

Note: Intake data was from Marigold staff report and exit data was from youth and parent report (with 100% agreement between youth and parents).

Juvenile Justice Involvement

Youth contact with the Juvenile Justice System is recorded in the statewide Juvenile Justice Information System (JJIS). From this statewide system, evaluators collected juvenile justice data for all youth to whom Marigold had provided service since program inception (n=95). The data presented below include all Marigold youth served from program inception to May 2004.

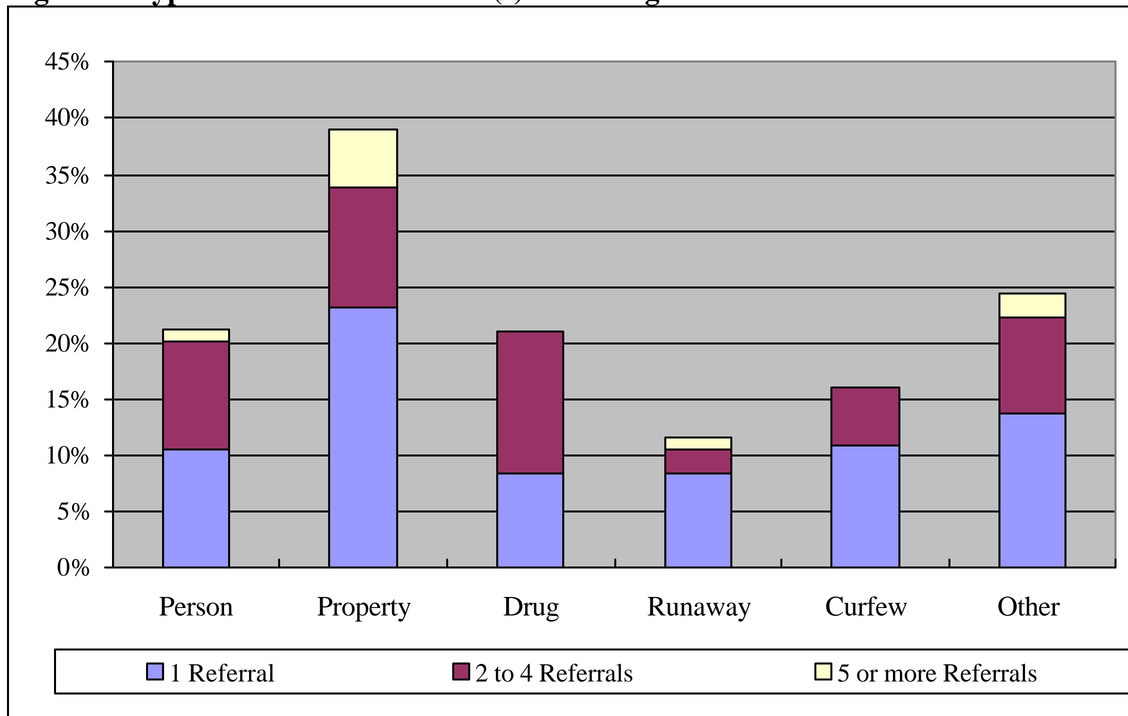
Juvenile Justice System Involvement Prior to Marigold Services

As of May 2004, Marigold had provided service to 95 youth and their families. Of these 95 youth served, 56 (59%) had at least one referral[11] to the Juvenile Justice System. Evaluators examined the types of referrals Marigold youth had prior to their program exit date. Out of the 95 youth, 21% (n=20) had one or more person related prior referral(s); 39% (n=37) had one or more property related prior referral(s); 21% (n=20) had one or more drug related prior referral(s); 12% (n=11) had one or more prior runaway referral(s); 16% (n=15) had one or more prior curfew referral(s) and 24% (n=23) had one or more "other" type of referral(s). [12] (See Figure 5 below.)

[11] Contact with the Juvenile Justice System is called a "referral." Referrals can include one or more charges or allegations. The data presented here report multiple charges (per referral). All but one of these 56 youth had at least one criminal contact with the Juvenile Justice System. One youth, however, had only non-criminal or status offenses (which include runaway and/or curfew violations).

[12] Person referrals included assault and sex assault; property referrals included arson, burglary, criminal mischief, trespass and theft; drug offenses included possession and distribution of a control substance; "other referrals included possession and manufacture of unlawful destructive device, forgery, fraud and endangering self/others.

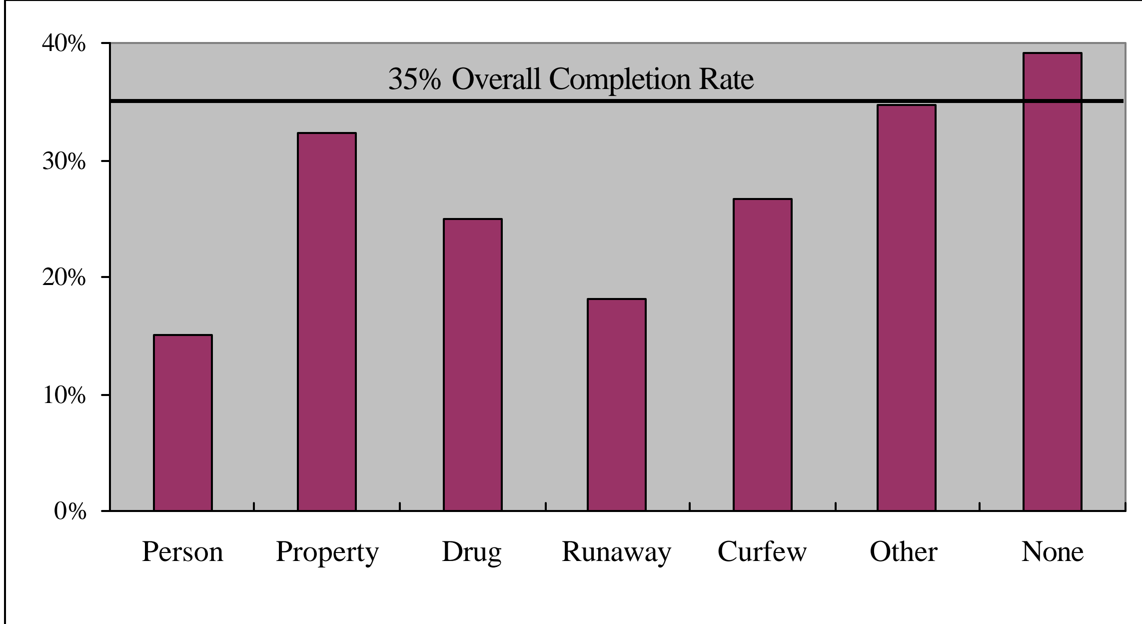
Figure 5. Type of Prior JJIS Referral(s) for Marigold Clients



The overall completion rate for these 95 Marigold youth was 35%.[13] Comparatively, of those with prior person referrals, 15% completed the Marigold program and only 18% of those with one or more prior runaway referrals completed. These percentages illustrate that youth with person and runaway prior referrals to the Juvenile Justice System tended to have lower Marigold completion rates compared to other youth. Similar to the overall rate, 32% of those with one or more prior property related referral(s) completed Marigold; 25% of those with one or more prior drug related referral(s) completed Marigold; 27% of those with prior curfew referral(s) completed; and 35% of those with "other" types of prior referral(s) completed. Thirty-nine percent of those with no prior contact with the Juvenile Department completed the Marigold program. (See Figure 6.)

[13] This completion rate was for the cumulative group of Marigold clients; the completion rate discussed in Chapter 3 was for Year 3 clients only.

Figure 6. Marigold Program Completion Rate by Type of Prior JJIS Referral(s)



Juvenile Justice System Involvement After Marigold Services

Objective: Youth who complete Marigold services will have lower recidivism rates than youth who do not complete Marigold services.

Outcome: Youth with prior juvenile justice system referrals who completed Marigold services had less recidivism than youth with prior referrals who did not complete Marigold services. Furthermore, of all youth who entered Marigold (regardless of whether they had prior offenses) youth who completed the Marigold program had lower rates of recidivism compared to those who had not completed Marigold. None of the youth who completed Marigold had new person, runaway, curfew or "other" type of JJIS referrals after one year. Comparatively, for youth who had failed to complete Marigold, 3% had new person referral(s), 19% had new runaway referral(s), 19% had new curfew referral(s) and 6% had "other" types of referral(s). Although similar proportions of youth completing and not completing had new property (9% and 11%, respectively) and drug (18% and 17%, respectively) referrals, those who completed Marigold had re-offended only once, while those who had not completed Marigold re-offended multiple times.

Recidivism rates were calculated for those youth with and without prior JJIS referrals. Analyses were conducted for all youth for whom JJIS data were collected as well as on the subset of youth who had reached their 12-month follow-up point (11 youth had not yet reached the 6-month follow-up point and 48 youth had not yet reached the 12-month follow-up point).

Recidivism rates six months after program exit for youth without prior JJIS referrals were calculated. Recidivism rates were similar regardless of whether or not the youth completed Marigold (17% for completers and 16% for non-completers). Likewise, recidivism rates six months after program exit for youth with prior JJIS referrals were calculated. For youth with prior JJIS referrals, one-fifth (20%) of those who completed Marigold recidivated within 6-months, while more than two-fifths (42%) of youth who failed to complete Marigold recidivated (see Figure 7).[14]

Figure 7. 6-Month Recidivism Rates

		Recidivism Rate:
Youth completing Marigold program (n=33)	Without prior referrals (n=23)	17% (n=4)
	With prior referrals (n=10)*	20% (n=2)
Youth not completing Marigold program (n=62)	Without prior referrals (n=38)	16% (n=6)
	With prior referrals (n=24)*	42% (n=10)

Note: Priors are in 6-month period prior to program exit.

A similar recidivism pattern existed 12 months after youth exited Marigold. Recidivism rates for youth without prior JJIS referrals, regardless of whether or not the youth completed Marigold, were similar (0% and 3%, respectively). Recidivism rates for youth with prior JJIS referrals, however, were substantially lower for youth who completed Marigold (15%) than for youth who failed to complete the Marigold program (32%), as illustrated in Figure 8 (see next page).

[14] For violent recidivism referral rates see Appendix C.

Figure 8. 12-Month Recidivism Rates

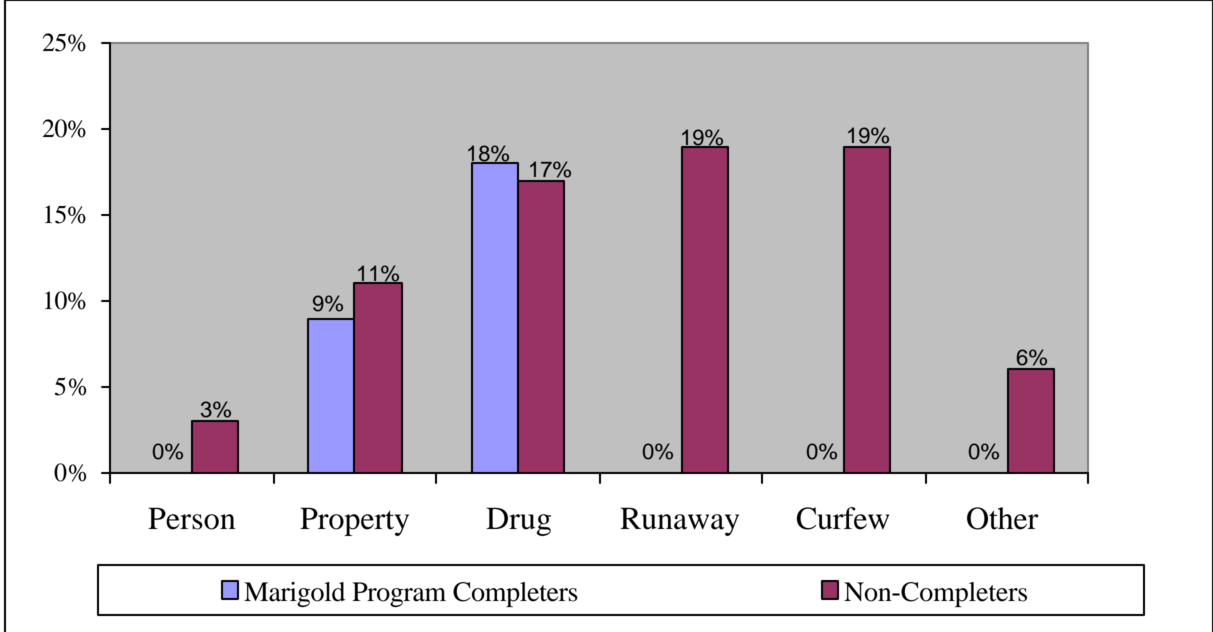
Group	Prior referrals		Recidivism Rate:
Youth completing Marigold program (n=33)	Without prior referrals (n=20)	→	0% (n=0)
	With prior referrals (n=13)*	→	15% (n=2)
Youth not completing Marigold program (n=62)	Without prior referrals (n=31)	→	3% (n=1)
	With prior referrals (n=31)*	→	32% (n=10)

Note: Priors are in 12-month period prior to program exit.

Recidivism rates were also calculated just for those clients for whom at least one year had past since their program exit date (n=47). Overall, youth who completed the Marigold program had lower rates of recidivism compared to those who had not completed Marigold. None of the youth who completed Marigold had new person, runaway, curfew or "other" type of JJIS referrals after one year. Comparatively, for youth who had failed to complete Marigold, 3% had new person referral(s), 19% had new runaway referral(s), 19% had new curfew referral(s) and 6% had "other" types of referral(s). Although similar proportions of youth completing and not completing had new property (9% and 11%, respectively) and drug (18% and 17%, respectively) referrals, those who completed Marigold had re-offended only once, while those who had not completed Marigold re-offended multiple times[15] (see Figure 9 on next page).

[15] One non-completing youth had seven property referrals after their program exit date.

Figure 9. Type of Recidivism One Year after Program Exit



Oregon Youth Authority Placement

Objective: No more than 20% of youth completing FFT therapy should be in Oregon Youth Authority (OYA) placement 12 months after therapy. *Outcome: No youth (0%) who completed FFT therapy were in OYA placement 12 months after therapy.*

OYA placement data were obtained from JJIS. Of the 56 youth with Juvenile Justice records, only two youth had been placed in OYA. These placements both occurred prior to the youth's Marigold program exit date. Therefore, no completing youth were in OYA placement 12 months after therapy.

Summary

The Marigold Program met its outcome objectives for the families completing therapy in Year 3. These families indicated marked improvement in family functioning, almost all youth completing therapy were enrolled in school or a vocational program, there are indications that youth significantly decreased their substance use, and youth completing therapy had less juvenile justice system involvement than youth who did not complete therapy.

Chapter 5: Summary of Findings and Recommendations

In this chapter we summarize the services provided by Marigold and the outcomes achieved by Marigold families. We highlight the program accomplishments, identify areas for improvement, and provide recommendations for Year 4.

Services Provided

Finding 1: The program had a diversified referral base and a streamlined intake process.

The Marigold program received referrals from 17 different sources during Year 3, compared to 15 referral sources in Year 2 and nine referral sources in Year 1. The program processed these referrals efficiently, with the median "zero" session occurring six days from the date of referral. The case manager captured data about referred families through the use of the new Referral Tracking Form as well as the JCP risk assessment.

Recommendation: The Marigold program should continue to build and maintain relationships with its referral sources, meet with families for a "zero" session soon after the referral is made, and continue using the Referral Tracking Form.

Finding 2: Despite a large number of referrals, the program's service delivery objective was not met.

During Year 3, 66 families began or continued therapy with Marigold. While over 100 families were referred to Marigold for services during Year 3, only 37% (n=43) of these families actually engaged in therapy. As discussed in Chapter 2, there was documentation as to why 24% (n=28) of families did not engage in services: some families decided that FFT was not the service they desired; some families were not eligible for services, and some families were not intact (runaway youth, homelessness). These circumstances that caused referred families to disengage from the referral process are out of the control of the Marigold program. However, it is unclear why another 38% (n=44) of the families failed to connect to a Marigold therapist. With a 37% engagement rate, Marigold would need to receive 270 referrals annually to serve 100 families.

Recommendation: Marigold may wish to focus attention on engaging as many "zero" session families as possible. The program could examine its current practice for attempting to engage families in therapy in light of the high numbers of families that complete "zero" sessions but do not begin therapy.

Recommendation: In order to ensure that 100 families are served each year, Marigold needs to increase the number of program-eligible referrals. That is, the program should continue and expand upon its work with potential referral sources to increase the number of referrals, and should repeatedly provide referral sources with information about Marigold eligibility criteria to ensure that referred families are, indeed, eligible for

Marigold services. Alternately, if the number of referral sources and the referrals these sources provide truly represents the universe of eligible families in Umatilla County, Marigold may wish to modify its objective of the number of families served each year.

Finding 3: The program served more boys than anticipated.

The Marigold program started serving boys in its second year of operation. Because the program wanted to maintain its focus on serving Umatilla County's girls and their families, the program set an objective of having 85% of cases be families with girls. However, data from Year 3 indicate that approximately 70% of families served were families of girls. The higher proportion of boys served is due to the program's practice of filling available slots immediately (with a waiting boy and his family) rather than keeping therapists' caseloads less than full in order to reserve spots for girls. This practice allows the program to stay at capacity, thus serving the largest possible overall number of families, but it does dilute the program's focus on girls and their families.

Recommendation: Marigold should either revise its objective of the proportion of girls to be served or should alter its practice of filling available slots with boys.

Finding 4: The program did not serve the Native American community.

Marigold received no referrals from the Native American community in Year 3. Outreach to the Native American community has been a challenge to the program since its inception.

Recommendation: Marigold staff should continue to attempt to build relationships with representatives from the Native American community.

Finding 5: Dropouts hindered the program's ability to meet its completion objective.

During Year 3, nearly 70% of families served completed therapy, a proportion slightly lower than the anticipated 80%. Families who dropped out of services after initially engaging influenced the completion rate: thirteen families dropped out of services, and 10 of these dropouts occurred during the Engagement and Motivation Phase. While three of these dropouts were due to families moving outside the service area, the remaining ten dropouts occurred despite repeated contact attempts by Marigold staff.

Recommendation: Marigold staff should examine the characteristics and case notes of the families who dropped out of services in order to identify any commonalities in the presenting issues, family demographics, or therapeutic strategies used with these families. Should commonalities exist, Marigold should identify ways to strengthen their services in those areas.

Outcomes for Families

Finding 6: Families who completed Marigold services reported improvement on almost all domains of family functioning.

At program exit, more than 80% of youth and their fathers reported improvement in four of the six Client Outcome Measure domains (overall family change, changes in communication, changes in adolescent behavior, and changes in family conflict), and more than 80% of mothers reported improvement in all six of the domains (the abovementioned four plus changes in parenting skills and changes in parental supervision). After 3 months, more than 80% of Year 3 families completing therapy showed improvement in all but one (change in adolescent behavior) of the COM domains.

Finding 7: Almost all youth who completed Marigold services were attending school or a vocational program after program completion.

Ninety-two percent of youth completing therapy were attending school or a vocational program at the close of therapy, and 93% were attending school or a vocational program three months after therapy.

Finding 8: Youth who completed Marigold services exhibited a marked decrease in substance use.

There was a 72% decrease in alcohol use and an 81% decrease in drug use between program intake and program exit for Year 3 youth who completed therapy.

Finding 9: Youth with person and runaway prior referrals to the juvenile system had lower Marigold completion rates than youth with property, drug, curfew, other, or no prior referrals.

Juvenile justice outcomes were examined for all Marigold clients, not just the subset of clients served in Year 3. Of those youth with prior person referrals, 15% completed the Marigold program, while 18% of those with one or more runaway referral completed Marigold, compared to an overall Marigold completion rate of 35%.[16]

Recommendation: In order to boost completion rates, Marigold may wish to redouble its efforts at retaining youth who have prior person and runaway referrals. Alternately, the program could determine that its services are not a good fit for youth with these types of prior juvenile justice referrals.

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[16] This completion rate is a cumulative rate for all Marigold clients, and therefore differs from the Year 3 completion rate discussed under Finding 5, above.

Finding 10: Youth with prior referrals to the juvenile justice system who completed Marigold services were less likely to recidivate than youth with prior referrals who did not complete Marigold services.

Recidivism rates after program exit for youth without prior JJIS referrals were similar for youth who completed and did not complete Marigold services. However, for youth with prior JJIS referrals, half as many (proportionately) of those who completed Marigold (compared to those youth who failed to complete Marigold) recidivated.

Recommendation: These data suggest that youth with prior juvenile justice referrals who complete Marigold may be less likely to recidivate than youth who do not complete the program. The program, therefore, should focus special attention on retaining youth with prior justice system involvement.

Conclusion

During Year 3, the Marigold Evaluation shifted emphasis from a process evaluation to an outcome evaluation. While the program fell short of meeting several of its service delivery objectives (number of families served, proportion of girls served, and proportion of families completing therapy), the program did meet its objectives in terms of outcomes for families. Families completing therapy reported improvement on many domains of family functioning, almost all youth completing therapy were enrolled in school, youth completing therapy showed a marked decrease in substance use, youth completing therapy who had a history of juvenile justice system involvement showed less recidivism than youth not completing therapy, and no youth completing therapy had a subsequent OYA placement. In Year 4, evaluators will continue to track all of these outcomes.

Appendix A: Program Description[17]

Program Overview

Purpose: The purpose of this program is to provide family focused services in a geographic area that has a paucity of resources for at risk youth, particularly at risk girls. HYFS has seen a need for girls' services for a number of years and, literally, there is nothing like this program in our county or adjacent counties. The incidence of girls entering the juvenile justice system is on the rise as are violent crimes committed by girls. Research suggests that girls' needs are better met by reaching them via their significant relationships (families) and helping to make positive changes in this arena that will support success. Additionally, at risk youth of both genders have been shown to benefit from family focused interventions that target risk and protective factors related to juvenile justice involvement. Thus, we are providing a family focused service with the aim of reducing their at-risk behaviors/factors and avoiding future problems with the law.

Program Goals: The program goals are to decrease juvenile justice system involvement, facilitate greater engagement in school and to have participating families reach improved levels of family functioning.

Program Theory: This program is utilizing the Functional Family Therapy model to provide family therapy services. FFT is a "Blueprint" program, one of 11 programs identified as having strong empirical support for their efficacy in reducing adolescent violence. FFT is a relatively brief family therapy program that involves a specific protocol, based on family systems theory, for helping families improve their functioning. It involves specific phases and techniques to accomplish this end and a specific training and supervision process is ongoing with our agency to be sure we are following protocol.

Program Participants

Target Group: This program is intended for adolescents between the ages of 11 and 18 residing in Umatilla or Morrow County who score as "at risk" on at least two factors within the JCP screening instrument. The program is designed to be gender specific and has 85% of its program openings available for girls and 15% for boys. The expected number of participants over a one-year period, with the program operating at full capacity, is 100.

Eligibility Requirements: see above.

Recruitment/Screening Process: Any agency or professional as well as families themselves can refer girls to the program. This involves making a phone call to the program and providing contact information for the family. We do ask that the referent let

[17] The Program Description was written by Elisa Doebler-Irvine.

the family know they are making the referral. With the family information, a member of our staff (usually the family case manager) places a call to the parents and confirms that the youth resides in Umatilla or Morrow County and is between 11 and 18. The caller then collects information regarding the impetus for the referral and completes the JCP with parent. On occasion, we receive a completed JCP from a referent or the referent completes the JCP over the phone when providing contact information. The youth needs to score as "at risk" in at least two of the areas on the JCP.

Service Delivery

Program Components: The primary component of the program is delivering FFT services to families of qualifying youth in Umatilla County. Included in this are family case management services (skills training, resource acquisition, referrals) during the course of therapy and especially during the generalization phase. Of course, a less central but important component is fostering and maintaining community relations so as to ensure a steady flow of referrals.

Program Activities: Program activities during FFT, are attendance at family therapy sessions (12 on average) and work with the family case manager to develop specific skills, acquire resources and find "aftercare" resources. In developing community relations, staff are involved in various activities promoting the program such as speaking on local radio shows, distributing printed program materials, attending community meetings, and so on.

Collaboration: Key stakeholders in the program include the Umatilla County Commission on Children and Families; Community Access for Resource Effectiveness; Juvenile Services Division; Oregon Youth Authority; Department of Human Services (formerly SCF); Umatilla County Health Department; area middle and high schools; Adult and Family Services, and other local mental health providers.

Each of these stakeholders has collaborated with HYFS through the development phase of the Marigold Program and currently make referrals to the program. The Commission on Children and Families provided $35,500 for start up funding and provides a portion of our required match amount annually. Other agencies have expressed a desire to provide coordinating services or be aftercare resources for youth who may need specialized services post FFT.

Program Resources

Funding: The Marigold Program is funded primarily through an Edward G. Byrne Memorial Grant. This grant is renewable for up to four years, ending September 2005. HYFS is required to provide a 25% match that has come from other foundations/grants as well as the general operating budget of HYFS. Other supporting funders include Umatilla County, the Wildhorse Foundation, and the Juan Young Trust.

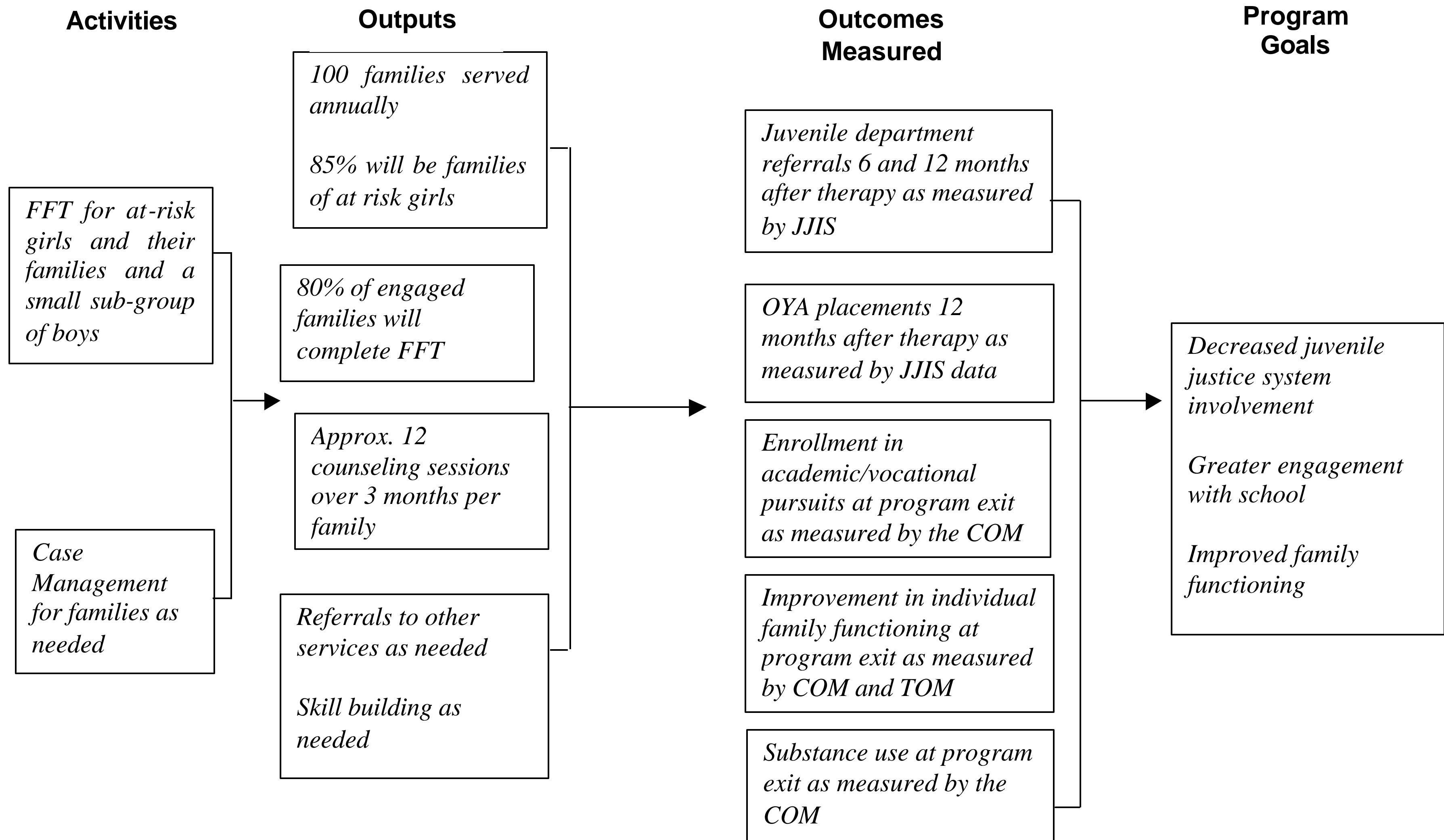
Staffing: A total of four staff are involved in service delivery. Elisa Doebler-Irvine, Ph.D. is the agency Executive Director and the Marigold Program direct supervisor. Elisa has a doctoral degree in Marriage & Family Therapy and a master's degree in Counseling Psychology. She is a Licensed Professional Counselor in Oregon and a Clinical Member and Approved Supervisor of the American Association for Marriage and Family Therapy. She has been a practicing clinician for 11 years with several additional years of social service and research experience. Recently, she was invited to become a National Implementation Consultant for Functional Family Therapy, Inc. and provides supervision for other sites across the United States who are implementing FFT in their communities.

Carmen Requa is the program Family Case Manager. She has a number of years of experience providing in-home visiting and skills training to at-risk families from a variety of cultures and socio-economic backgrounds. She is a certified post-partum doula and a member of Project Cuddle helping prevent the abandonment of newborns. Carmen is responsible for the referral and intake process to the program as well as providing skills training and case management services on an as needed basis. Her role is as a support to the therapy process.

Tom Logan, MA and Theresa Adkins, MSW are full time Functional Family Therapists. They are responsible for providing FFT to families. Tom holds a master's degree in counseling psychology and has six years experience in the counseling field in community mental health settings. Theresa holds a master's degree in social work. She is also a licensed vocational rehabilitation counselor and has experience working with a range of presenting problems and populations in outpatient settings.

All four program staff have been involved with and attended the Functional Family Therapy trainings and consultations. The program has successfully completed Phases I and II toward site certification by FFT. This includes an initial three day training; a two day site visit to get the program up and running, weekly telephone consultations for the first year, the quarterly two day site visits with our FFT consultant in year one, bi-monthly calls with the site supervisor and an FFT consultant in year two, the site supervisor attended two two-day trainings focused on clinical supervision of FFT sites and the program had one site visit during year two. Marigold is currently in the third and final phase toward site certification which involves continued contact with FFT at but at less intense levels. Further, in year three, Marigold organized a two-day retreat attended by two additional Oregon FFT sites that provided a 'refresher' overview of FFT.

Appendix B: Marigold Program Logic Model



Appendix C: Violent Referrals

Figure C1. Percent of all Marigold youth with violent JJIS referral(s) 6-months after Marigold Exit

Group	Prior violent referrals	Result
Youth completing Marigold program (n=33)	Without prior violent referrals (n=32)	3% (n=1)
	With prior violent referrals (n=1)*	NR
Youth not completing Marigold program (n=62)	Without prior violent referrals (n=55)	2% (n=1)
	With prior violent referrals (n=7)*	29% (n=2)

Note: Group sizes less than ten are not reported (NR). Priors are violent referrals in 6-month period prior to program exit.

Figure C2. Percent of all Marigold youth with violent JJIS referral(s) 12-months after Marigold Exit

Group	Prior violent referrals	Result
Youth completing Marigold program (n=33)	Without prior violent referrals (n=32)	0% (n=0)
	With prior violent referrals (n=1)*	NR
Youth not completing Marigold program (n=62)	Without prior violent referrals (n=53)	2% (n=1)
	With prior violent referrals (n=9)*	NR

Note: Group sizes less than ten are not reported (NR). Priors are violent referrals in 12-month period prior to program exit.