An Evaluation of the Marigold Program, Umatilla County, Oregon

Year 4 Evaluation Report

Submitted to:

Elisa Doebler-Irvine
Homestead Youth & Family Services
816 SE 15th St.
Pendleton, OR 97801

Submitted by:

Jodi Brekhus, M.S.
Sonia Worcel, M.A., M.P.P.

October 2005

NPC RESEARCH
4380 SW Macadam Ave., Suite 530
Portland, OR 97239
(503) 243-2436
www.npcresearch.com

An Evaluation of the Marigold Program
Umatilla County, Oregon

Year 4 Evaluation Report

Jodi Brekhus, M.S.
NPC Research
brekhus@npcresearch.com

Sonia Worcel, M.A., M.P.P.
NPC Research
worcel@npcresearch.com

October 2005

Research designed to promote effective decision-making by policymakers at the national, state and community levels

ACKNOWLEDGEMENTS

NPC Research wishes to thank the Marigold staff for their time and openness to the evaluation process during this past year. Specifically, NPC wishes to thank Carmen Requa for her unfailing assistance with the data collection and with her willingness to help the evaluation team with multiple requests. Additionally, we would like to thank Linda Newton-Curtis, Ashley Andrews and Alex Hall for their assistance with data processing.

EXECUTIVE SUMMARY

During Year 4, Marigold achieved many of its objectives. Marigold reached its *service delivery* objective of the proportion of girls served. However, the program fell short of its *service delivery* objectives in terms of the number of families receiving FFT and the proportion of families completing therapy. Marigold met many of its *outcome* objectives, including family functioning improvement, school attendance and fewer youth using drugs.

The Year 4 Evaluation Report highlights several findings.[1]

- The program received a large number of referrals, assessed more than half, and transferred almost a third to therapists for FFT.
- Although Marigold only provided FFT service to about three-fourths of its projected number of families, the program provided other services to additional families including booster sessions, referrals, and case management.
- The program met its objective of maintaining an emphasis on serving girls.
- The program served a disproportionately small percentage of Hispanic families (7% of families served were Hispanic compared to 16% in the general population).
- The proportion of families completing FFT was lower than desired.
- For the Marigold Year 4 participants who completed FFT, a large proportion of youth, mothers, fathers, and therapists reported family functioning improvements at exit.
- Almost all youth who completed Marigold services were attending school or a vocational program at program completion.
- For those youth who completed FFT, few were using alcohol and/or drugs at the end of therapy.

The Marigold program received 165 unique referrals from more than 19 sources during Year 4. The case manager used the JCP to assess the number of risk factors for 51% of referrals (N=84). After assessment, the case manager connected eligible families (30% of all referrals) with a therapist (N=49). Chapter 2 documents the referral process along with reasons why families dropped out of the process.

During Year 4, Marigold provided FFT to 76 families and booster sessions to an additional 4 families as well as referrals and/or case management to an additional 26 families. The program met its objective of maintaining an emphasis on serving girls, as 75% of the youth served during Year 4 were female. However, considering that county statistics report 16% of the general

[1] Year 4 refers to the time period between July 1, 2004, and June 30, 2005.

Umatilla County population are Hispanic, Marigold's served a disproportionately small percentage of Hispanic families (7%). Referral data illuminated that most referred Hispanic families (85%) were also Spanish speaking families. Chapter 3 describes the families served and gives explanation to the program retention rate of 56%.

Chapter 4 presents outcome data for families who completed FFT. For instance, a large majority of Marigold youth, mothers, and fathers showed improvement in six family functioning domains. Additionally, 94% of youth who completed Marigold were attending school or a vocational program at program exit. Furthermore, as of program exit (compared to at program intake), 21% fewer youth were using alcohol; 70% fewer youth were using drugs; and 70% fewer youth were using both alcohol and drugs.

Table of Contents

EXECUTIVE SUMMARY I
CHAPTER 1: PROGRAM DESCRIPTION AND OBJECTIVES 1
Target Population 1
Program Objectives 1
Program Components 2
Functional Family Therapy 2
Program Staff 3
Case Management 3
Program Evaluation 3
Year 4 Evaluation Report 4
CHAPTER 2: REFERRAL PROCESS 5
Number of Referrals and Referral Sources 5
Demographics of Youth Referred 6
Stages of the Referral Process 7
Program Engagement 8
Summary 9
CHAPTER 3: FAMILIES SERVED AND RETENTION 10
Demographics of Families Served 10
Assessment Scores 11
The Outcome Questionnaire (OQ45.2) 11
The Family Assessment Measure (FAM) 11
Youth Outcome Questionnaire (YOQ) 12
Presenting Issues 13
Retention 14
Summary 16
CHAPTER 4: OUTCOMES FOR YOUTH AND FAMILIES 17
Family Functioning 17
School Attendance 18
Substance Use 19
Summary 19
CHAPTER 5: SUMMARY OF FINDINGS 20
Services Provided 20
Outcomes for Families 20
Conclusion 21

APPENDIX A: MARIGOLD PROGRAM LOGIC MODEL 22
APPENDIX B: PROGRAM DESCRIPTION.....24

List of Figures

Figure 1. Referrals Sources for Year 4 6
Figure 2. Number of Referred Families in Year 4 who engaged in Marigold's FFT Services 7
Figure 3. Presenting Issues for Families Served in Year 4 14
Figure 4. Number of FFT Sessions Year 4 Drop-Out Families Attended 15

List of Tables

Table 1. Reasons Year 4 Families Failed to Participate in a "Zero" Session 8
Table 2. Percentage of Year 4 Families with OQ45.2 Scores in Clinical Range 11
Table 3. Percentage of Year 4 Families with FAM Scores in Clinical Range.....12
Table 4. Percentage of Year 4 Families with YOQ Scores Clinical Range.....13
Table 5. Average Number of Therapy Sessions for Year 4 Completers and Drop-Outs 15
Table 6. Percent of Year 4 Completing Families Indicating Improvement on the COM/TOM 18
Table 7. Substance Use Among Year 4 Completing Youth 19

CHAPTER 1: PROGRAM DESCRIPTION AND OBJECTIVES

Target Population

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.

The Marigold program now serves 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 75% 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 Department, middle and high schools, social service agencies, and mental health agencies.

Program Objectives

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 use alcohol and/or drugs after completing therapy. Fourth, with improved family relations and communication, participating youth will reduce their delinquent behavior, and, as a result, juvenile justice system referrals will be reduced.

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 25% boys;
- 80% of families served will complete therapy;
- 80% of those families completing therapy will show improved 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.

Because most families served during Year 4 did not finish Marigold 6 or 12 months prior to this report, data on the last two objectives will not be reported here, but will be reported for all Marigold families in the Project Close-Out Report.

Appendix A includes a logic model that illustrates the link between program goals, outcome measurement, and program activities.

Program Components

Below we describe the components of the Marigold program, including Functional Family Therapy, program staff and case management.[2]

FUNCTIONAL FAMILY THERAPY

Functional Family Therapy (FFT) 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 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." [3] 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

[2] Appendix B contains a program description with additional information including funding and more detailed information on service delivery and staffing.

[3] 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.

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

At the beginning of Year 4, Marigold staff consisted of the program director/clinical supervisor, two therapists, an intern, and a case manager. Half way through Year 4, however, one therapist resigned. At this time, the intern was promoted to a therapist and Marigold finished Year 4 with two therapists. Each therapist carries a maximum caseload of 12 families, and the therapists' caseloads are often full. The program director provides weekly clinical supervision to the Marigold therapists and serves as an additional therapist with a reduced caseload (between 2 and 3 families). The program director also contracts with FFT as a "national implementation consultant" which affords Marigold additional training materials.

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 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, stipulated that the grantee create a program description, logic model, and comprehensive evaluation plan (CEP) that outlined the program's goals and objectives along with plans for measurement, data collection, and analysis. Phase 2, Process Evaluation, required 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, required 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, a Portland-based research and evaluation firm, to serve as the external evaluator for the Marigold program. NPC Research worked with Homestead to ensure that the agency complied 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, 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. During Year 2, NPC researchers gathered referral information from a referral tracking form developed for this evaluation. Researchers also collected information (such as family intake data, demographics, assessment scores and presenting issues) from the Client Services System (CSS), a Web-based case management system designed by FFT. The Year 2 report was released in September 2003.

During the third and fourth years of the project, the focus of the evaluation activities shifted from the process evaluation to outcome monitoring. During Year 3, NPC researchers began collecting juvenile justice data to monitor criminal involvement. The Year 3 report was completed in September 2004.

The primary outcomes of interest for the evaluation are family functioning, school attendance, substance use, and juvenile justice involvement. To measure family functioning, school attendance and substance use, the evaluation relied upon a modified version of 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. NPC modified the COM to also include information regarding school attendance and substance abuse. In addition, therapists complete a similar measure for each family called the Therapist Outcome Measure (TOM).

To measure juvenile justice system involvement, data are gathered from Oregon's Juvenile Justice Information System (JJIS). NPC researchers collected juvenile justice data for each participant for the period of time 12 months prior to Marigold participation and 12 months after termination or completion. However, for Marigold youth served during Year 4, a 12-month period of time after exit had not yet elapsed. Therefore, juvenile justice involvement will not be reported here but will be reported for all families in the cumulative Marigold project closeout report.

Year 4 Evaluation Report

The remainder of this report documents NPC's outcome evaluation of Marigold's forth year[4] of implementation. 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 family functioning and substance use outcomes at the time of program exit. The final chapter of the report, Chapter 5, summarizes the evaluation findings.

[4] Year 4 includes youth referred, served or exited (completers and drop-outs) between July 1, 2004, and June 30, 2005.

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 (JCP) risk assessment tool, and program engagement.

During Year 4, 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 obtained 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 had at least two JCP risk factors, 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. If the family was interested in receiving therapy from Marigold at that time, the case manager connected the family to one of the Marigold therapists in order to schedule a time for an initial therapy session.

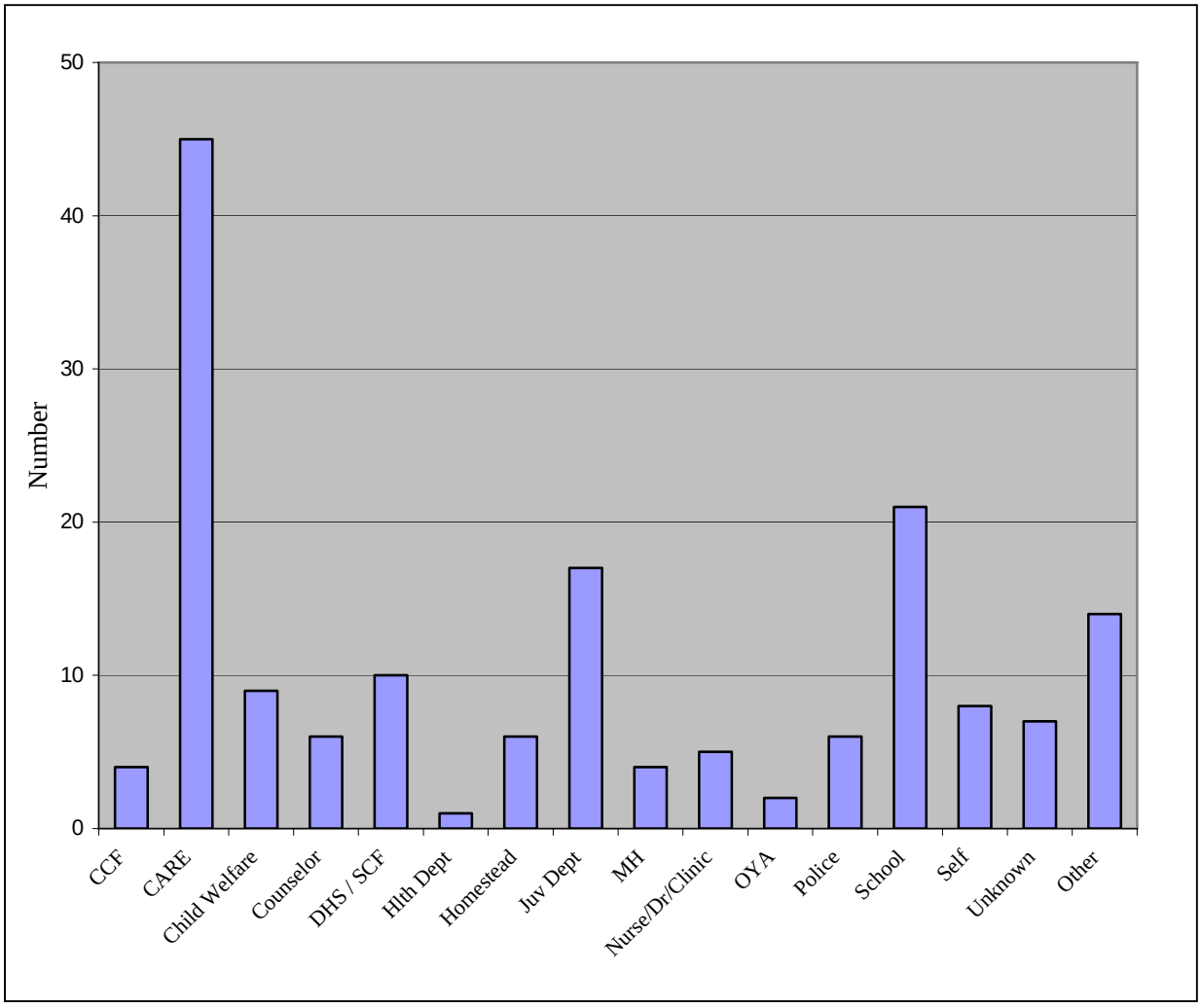
Number of Referrals and Referral Sources

During Year 4, Marigold received 165 unique referrals[5] from more than 19 different sources. Marigold received an average of 14 referrals each month with slightly fewer referrals in June (N=6) and slightly more referrals in January (N=21). Figure 1 illustrates the number of referrals by referral source for Year 4. During Year 4, Marigold received a substantial increase in referrals (compared to Year 3) from CARE (a school-based resource program), the Juvenile Department, and other sources.[6] Marigold experienced a slight decrease in referrals (compared to Year 3) from the Health Department, Homestead, and Mental Health.

[5] Five youth were referred twice during Year 4.

[6] Other referral sources included Tanya's House (a runaway shelter), Salvation Army, the newspaper, and the telephone book.

Figure 1. Referrals Sources for Year 4



Demographics of Youth Referred

During Year 4, Marigold received almost twice as many referrals for girls (65%) than for boys (35%). The average age of youth referred to Marigold was 14 years old. The majority of youth referred (77%) were Caucasian, non-Hispanics (N=115). Thirteen percent (13%) of those youth referred were Hispanic (N=20), 2% were African American (N=3), 2% were Native American (N=3), 1% was Asian (N=1) and 5% were multi-racial (N=7).[7] These proportions are similar to the ethnicity proportions of Umatilla County (78% Caucasian, 16% Hispanic, 3% Native American, 1% Asian, 1% African American and 2% multi-racial).[8]

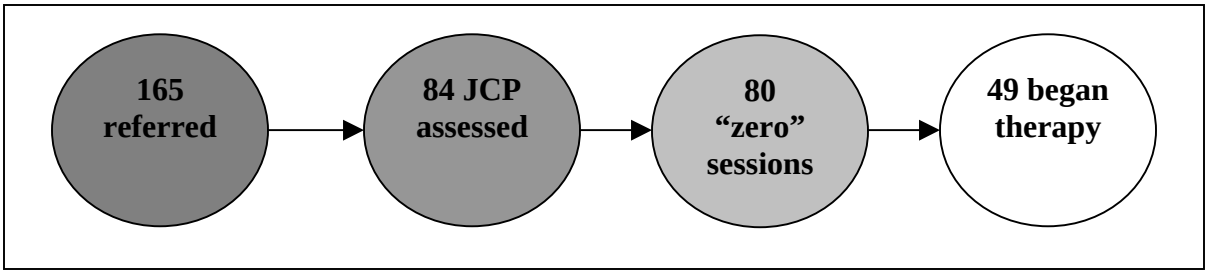
[7] Sixteen cases (N=16) were missing ethnicity data.

[8] Source: U.S. Census Bureau http://quickfacts.census.gov/qfd/index.html. Note: Due to some respondents reporting multiple races, percentages sum to slightly more than 100%.

Stages of the Referral Process

Of the 165 unique cases referred to Marigold during Year 4, 84 (51%) completed a Juvenile Crime Prevention (JCP) risk assessment, 80 (48%) had a "zero" session (at which time families completed initial program paperwork), and 49 (30%) had at least one FFT session. (See Figure 2.)

Figure 2. Number of Referred Families in Year 4 who engaged in Marigold's FFT Services



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 84 youth with JCP data, the total number of risk factors ranged from 1 to 19 (of a possible 29), with youth averaging 8 risk factors. Fifty-seven percent (57%) of the youth with JCP risk data had a least one risk indicator in the School Domain; 61% had one or more risk factors in the Peer Relationships Domain; 77% had risk indicator(s) in the Behavioral Issues Domain; almost all (99%) were at risk in the Family Functioning Domain; and 39% had at least one risk factor in the Substance Abuse Domain.

In terms of protective factors, referred youth had a total number of protective factors ranging from 0 to 9 (of a possible 11), with an average of 4 protective factors. Sixty-four percent (64%) of the youth had a least one protective factor in the School Domain; 54% had one or more protective factors in the Peer Relationships Domain; 28% had a Behavioral protective factor; 35% had a protective factor in the Family Functioning Domain; and 90% had a Substance Abuse related protective factor.

Documentation from the referral tool illuminated some of the reasons why some referred families did not have a JCP assessment and/or participate in a "zero" session. For instance, 20 referred family never responded to Marigold's outreach; 14 referred families wanted another type of service or referral; in 9 cases, the referral source failed to provide Marigold with adequate background information about the family; 7 referred youth did not meet the minimum age requirement (they were under 11 years old); 5 referred families were not interested in participating in Marigold's services; and 4 referred families failed to attend or complete zero session paperwork (see Table 1 below). However, 80 (48%) 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 64, with a median of 7 days.

Table 1. Reasons Year 4 Referred Families Failed to Participate in a "Zero" Session

Reason	Number of Families
Referred family never responded to Marigold's outreach	20
Family wanted another type of service or referral (individual counseling, residential facility, etc.)	14
Referral source failed to provide Marigold adequate background information about the family	9
Youth did not meet Marigold's age requirements	7
Not interested or ready to participate in Marigold's program	5
Family failed to attend or complete zero session paperwork	4
Family had unstable housing	4
Family moved out of service location	2
Interpreter was not available	2
Other	5
Reason was not documented	13
TOTAL	**85**

Analyses were conducted based on demographics to determine if there was a pattern of which youth were more or less likely to participate in a "zero" session. Of the Caucasian (non-Hispanic) population of referred youth, 74% participated in a "zero" session. Thirty percent (30%) of Hispanic youth referred participated in a "zero" session. Five of the eighteen youth (28%) who spoke Spanish as their primary language participated in a "zero" session. Two of the three (67%) African American youth and one of the three (33%) Native American youth referred participated in a "zero" session. The only Asian youth referred participated in a "zero" session.

Program Engagement

Overall, 30% of referred families engaged in service (attended at least one FFT session). Of the 80 families who completed a "zero" session, 49 (61%) families engaged in the Marigold program (attended at least one FFT session) while 31 failed to engage. During Year 4, Marigold

maintained a waiting list of families who completed a "zero" session and were waiting for an available counselor to begin FFT. It is likely that a large portion of these 31 families were waiting for an open place on a counselor's caseload. However, 4 of these 31 families, who completed a "zero" session but failed to engage, were assigned a Marigold FFT therapist but never began therapy.

In addition to the 49 families who engaged in Marigold, 26 of the referred families who did not engage received either a referral or case management services from the Marigold case manager (including housing assistance, assistance with treatment placement for youth, and domestic violence safety planning).

Analyses were conducted to determine if there was a pattern of which youth were more or less likely to engage in the Marigold program. Of the Caucasian (non-Hispanic) population of referred youth, 32% engaged in Marigold. One of the three (33%) African American youth and one of the three (33%) Native American youth referred engaged in the program. The only Asian youth referred engaged. However, only one of the twenty Hispanic youth referred (5%) engaged and only one of eighteen (6%) of the youth for whom Spanish was their primary language engaged in the Marigold program. The small percentage of Hispanic and Spanish speaking youth engaging in Marigold is likely due to the lack of a Spanish speaking therapist on staff.

Youth who engaged in the Marigold program (those who had at least one FFT session) had slightly fewer JCP risk factors on average (8) compared to those who did not engage (9). This pattern was true across domains except for the School Domain. On average, those youth who engaged also had slightly more protective factors (4) compared to those who did not engage (3). This pattern was true across domains.

Summary

The Marigold referral process operated in a similar fashion as in prior years. In comparison to Year 3, Marigold received a greater number of referrals during Year 4 (165 versus 115) from more than 19 different referral sources. Youth referred mirrored the ethnicities of Umatilla County youth. Almost all youth (99%) assessed with the JCP had at least one Family Functioning risk factor.

Eighty of the 165 referred families (48%) completed initial program paperwork. The reasons why 85 (52%) referred families failed to complete initial paperwork varied, with the most common reason being that the family never responded to initial contact from Marigold.

Of the 165 families referred to Marigold, 49 (30%) engaged in the program. About a third of youth from each ethnic group engaged with the exception of only 5% of Hispanics engaging. This result could be due to the lack of Spanish speaking staff. The youth engaging in Marigold had a similar number of JCP risk factors to those who did not engage. In addition to the 49 families who engaged, 26 families received a referral for more appropriate services or immediate case management services from the Marigold case manager.

CHAPTER 3: FAMILIES SERVED AND RETENTION

Objective: 100 families will be served.
Output: 76 families were served.

During Year 4 Marigold provided service (defined as a family having at least one Engagement and Motivation Phase session) to 76 families.[9] As discussed in Chapter 2, an additional 26 families were provided a referral to more appropriate service and/or received immediate case management services, however, these families did not engage in Marigold's FFT services. Moreover, an additional 4 families severed by Marigold in previous years received booster sessions during Year 4. Families receiving booster sessions during Year 4 participated in, on average, close to 3 booster sessions per family.

The remainder of this chapter will focus on describing the demographics and presenting issues of the Year 4 families served (N=76) as well as discussing retention and dropout rates for these families.

Demographics of Families Served

Objective: 75% of clients served will be girls.
Output: 75% of clients served were girls.

The program met its objective of maintaining an emphasis on serving girls, as 75% of the youth served during Year 4 were female.

The average age of youth served was 14, with an age range of 11 to 18 years old. Ethnicity data were available for 73 of the 76 youth. The majority of youth were Caucasian (86%), and smaller numbers of youth served were Hispanic (7%), Asian (3%), African American (1%), and Native American (1%).[10] Although the ethnic proportions of youth *referred* were similar to the ethnic proportions of the general Umatilla County population, Marigold served a substantially greater proportion of Caucasians and a slightly greater percentage of Asians compared to the general Umatilla County population. However, Marigold served a substantially smaller proportion of Hispanics and a slightly smaller proportion of Native Americans compared to the proportions in Umatilla County. The small percentage of Hispanic youth served by Marigold, compared to the percent of Hispanics in the Umatilla County population, may be due to lack of a bilingual therapist on staff.

Information about parental marital status was available for 46 of the 76 families; 48% of the parents in these families were married; 39% of the parents in 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) were available for 44 families. Sixteen percent (16%) of these families were mandated to participate in Marigold services.

[9] Some of these families were newly enrolled during Year 4 and some families began services in Year 3 but continued to participate (or exited service) during Year 4.

[10] Due to rounding, percentages may sum to slightly more or less than 100%.

Assessment Scores

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.

THE OUTCOME QUESTIONNAIRE (OQ45.2)

The OQ45.2 is a self-report assessment that measures the youth'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 over half of youth scored themselves in the clinical range on all subscales. Over half of mothers rated their children in the clinical range on the Interpersonal Relations subscale (see Table 2 below).

Table 2. Percentage of Year 4 Families with OQ45.2 Scores in Clinical Range

Subscale	Youth (N=51)	Mother (N=51)	Father (N=27)
Symptom Distress	51%	41%	19%
Interpersonal Relations	61%	53%	41%
Social Role	61%	45%	36%

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 family information in seven areas. Table 3 illustrates the percentage of youth, mothers, and fathers who rated their family as scoring in the clinical range on seven subscales: the Task Accomplishment subscale, indicating they had problems with basic tasks or identifying solutions to problems; the Role Performance subscale, indicating a lack of agreement among family members regarding role definitions or an inability to adapt to new roles; the Communication subscale, indicating problems with communication or a lack of understanding of other family members; the Affective Expression subscale, indicating family members either lacked sufficient expression or had overly emotional responses with one another; the Involvement subscale, indicating either insufficient family involvement or a lack of autonomy or narcissistic involvement; the Control subscale, signifying 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. Overall, less than 15% of youth, mothers, and fathers rated their family as scoring in the clinical range on these subscales.

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

Subscale	Youth (N=51)	Mother (N=50)	Father (N=27)
Task Accomplishment	8%	12%	11%
Role Performance	6%	6%	4%
Communication	8%	12%	14%
Affective Expression	10%	12%	7%
Involvement	8%	6%	7%
Control	4%	6%	11%
Values and Norms	8%	4%	7%

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 rated the youth as scoring 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 youth 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 4 Families with YOQ Scores Clinical Range

Subscale	Youth (N=50)	Mother (N=48)	Father (N=27)
Interpersonal Distress	64%	79%	79%
Somatic	74%	71%	61%
Interpersonal Relations	0%	0%	0%
Social Problems	78%	94%	89%
Behavioral Problems	64%	75%	85%
Critical Items	74%	69%	78%

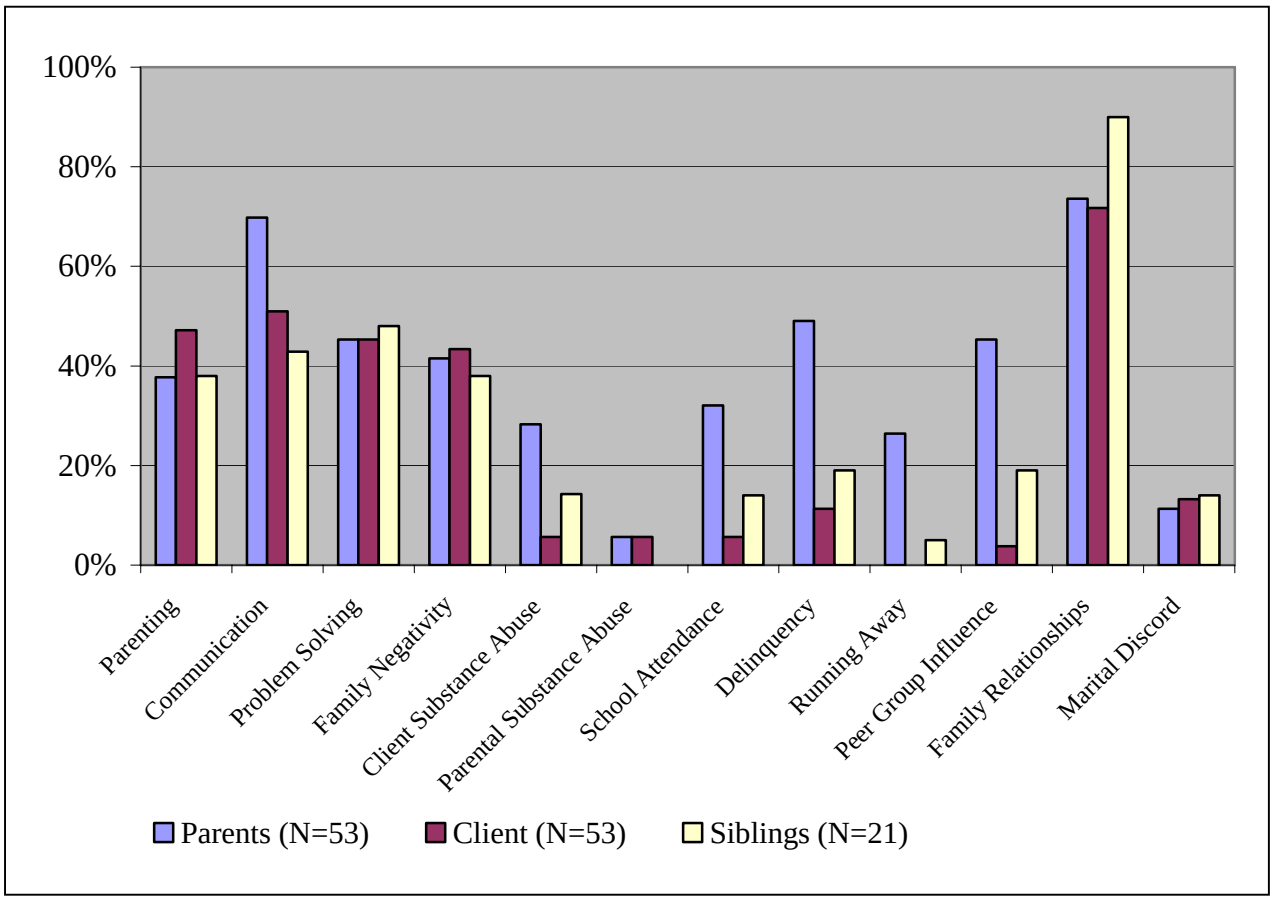
Note: Subscales with 50% or more in clinical range are shaded gray.

Presenting Issues

After each therapy session, Marigold therapists recorded a narrative description of each family's situation and challenges. The notes from the first therapy session contain information regarding the families' presenting issues. Therapists also recorded whether each family member (father, mother, client, and/or siblings) identified any one of a series of issues as a problem area for the family.

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

Figure 3. Presenting Issues for Families Served in Year 4



Retention

Objective: 80% of families served will complete therapy.
Output: 54% of families served completed therapy.

At the end of Year 4, there were 17 families who were still receiving FFT from Marigold and 59 families who had exited Marigold. Of those 59 families who exited Marigold during Year 4, 54% (N=32) completed therapy[11] and 46% (N=27) dropped out of therapy.[12] The average number of days participating in Marigold for completers was significantly greater (184 days) than for drop-outs (94 days) ($p < .001$). Likewise, completing families had significantly more Engagement, Behavioral, Generalization, and Total sessions compared to drop-outs. Table 5 shows that, on average, completers attended 13 total sessions, while drop-outs, on average, attended only 4 sessions.

[11] Completing therapy is defined here as completing at least one Generalization Phase session.

[12] Dropping out of therapy is defined as engaging in therapy but failing to complete at least one Generalization Phase session.

Table 5. Average Number of Therapy Sessions for Year 4 Completers and Drop-Outs

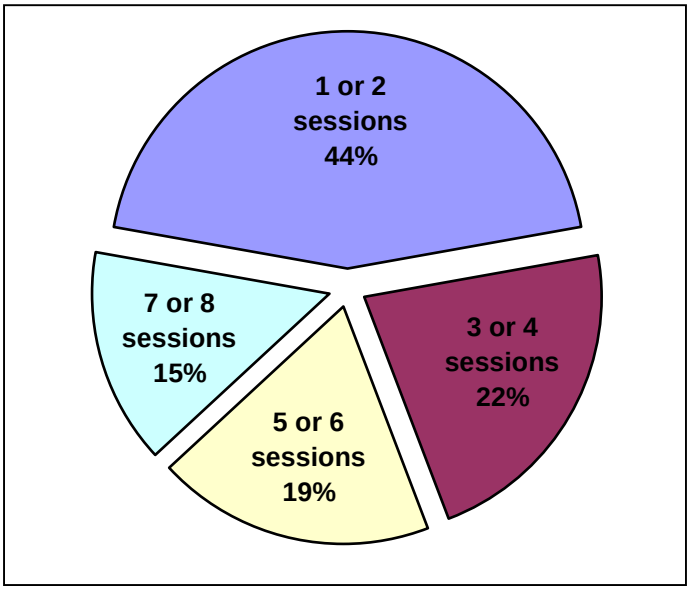
	N	Engagement & Motivation	Behavior Change	General-ization	Total Sessions
Completers	32	5	4	4	13
Drop-Outs	27	3	1	0	4

Note: All comparisons between completers and dropouts were statistically significant ($p \leq .001$)

Data suggest that Marigold faces challenges retaining families early in the Engagement and Motivation phase of therapy. Almost three-fourths (74%) of the 27 drop-outs withdrew from FFT during the Engagement and Motivation phase. Figure 4 shows that 44% of families dropped out after one or two FFT sessions; 22% of families dropped out after three or four FFT sessions; 19% dropped out after five or six FFT sessions; and 15% dropped out after seven or eight FFT sessions.

For the 27 families who withdrew from FFT, the narrative descriptions of their final session were reviewed. Five families had case notes that conveyed the reasons these families disengaged: in three cases, the youth refused to participate; in one case, the parent refused to participate; and in one case, the family believed they did not need therapy.

Figure 4. Number of FFT Sessions Year 4 Drop-Out Families Attended (N=27)

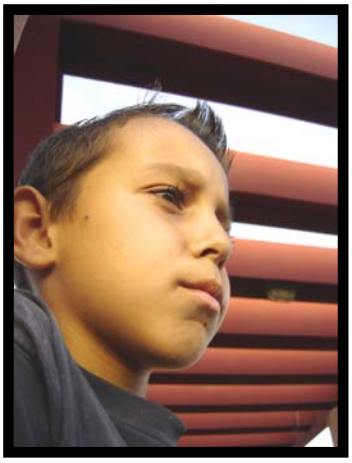


Summary

Marigold served 76 families during Year 4, three-fourths of whom were families with female adolescents. The assessment scores and presenting issues for these youth and their families indicated that many were struggling with emotional, physical and behavioral problems; family relationships; and communication.

During Year 4, 54% of families served completed therapy and 46% dropped out. Families were most likely to withdraw from FFT after the first or second therapy sessions.

CHAPTER 4: OUTCOMES FOR YOUTH AND FAMILIES



This chapter reports on the outcomes for youth and families at the time of program exit. Reported outcomes include family functioning, school attendance, and substance use. Data on outcomes at the time of program exit are reported for completing[13] Year 4 families (N=32).

Family Functioning

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

Outcome: At exit, more than 80% of youth completing therapy reported improvement in five of the six COM domains, and more than 80% of mothers and fathers reported improvement in all six of the COM domains.

Each family member completed the Client Outcome Measure (COM), a required FFT measurement tool, during the last therapy session. This measure asks 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. Therapists also rated the family's level of change in these six domains. Ratings are on a six-point response scale (0='Things are worse', 1='No change', 2='Only a little better', 3='Somewhat better', 4='A lot better', and 5='Very much better').

Table 6 shows, for each of the six COM domains, the percent of youth, mothers, and fathers who indicate that positive change occurred and the percent of *families* who indicate positive change occurred.[14] Also presented in Table 6 is the percentage of families showing positive change according to therapist's ratings (Therapist Outcome Measure) in each of the six domains. Lastly, Table 6 shows (**in bold**) the percent of youth, mothers, and fathers reporting improvement in <u>all</u> six domains.

At exit, 80% or more of Year 4 youth who completed therapy reported improvement[15] in five of the six COM domains. Likewise, 80% or more *families* reported improvement in five of the six domains. Moreover, more than 80% of Year 4 mothers and fathers completing therapy rated favorable change in all six COM domains. Therapists indicated that 80% or more of families made positive change in five of the six domains.

[13] Completing therapy is defined here as completing at least one Generalization Phase session.

[14] The families who indicated positive change were those families in which every family member (who provided a response) responded with a rating of 2 or higher.

[15] Improvement is defined as a response scale rating of a 2 or higher.

Table 6. Percent of Year 4 Completing Families Indicating Improvement on the COM/TOM

COM/TOM Domain	Youth (N=16)	Mother (N=18)	Father (N=8)	All Family Members	Therapist (N=25)
Overall Family Change	94%	94%	100%	95%	94%
Change in Communication Skills	94%	100%	100%	89%	100%
Change in Adolescent Behavior	94%	89%	100%	89%	80%
Change in Parenting Skills	94%	94%	100%	89%	76%
Change in Parental Supervision	75%	94%	100%	79%	84%
Change in Conflict	94%	94%	100%	95%	92%
Improvement in ALL Domains	**75%**	**89%**	**100%**	**68%**	**68%**

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

Note: Improvement is defined as a response scale rating of 2 or higher on the six-point response scale (0='Things are worse', 1= 'No change', 2='Only a little better', 3='Somewhat better', 4='A lot better', and 5='Very much better')

School Attendance

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

Outcome: 94% of Year 4 youth who completed therapy were attending school or a vocational program at the close of therapy.

Data on school attendance at the close of therapy was captured on the exiting COM. Data were available for all (N=32) Year 4 youth who completed therapy. At the close of therapy, 30 (94%) youth were attending school.

Substance Use

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

Outcome: For Year 4 youth who completed therapy, as of program exit, 21% fewer were using alcohol; 70% fewer were using drugs; and 70% fewer were using both alcohol and drugs.

The Marigold case manager and counselors provided a report of the youth's alcohol and drug use at the time of program intake. Additionally, both the youth and the parents were asked to report the youth's alcohol and drug use at the time of exit (on the exiting COM).

For the 32 youth who completed therapy, at the time of program intake, 7 youth were using alcohol, 8 youth were using drugs, and 4 were using both alcohol and drugs. At program exit, youth reported their alcohol and drug usage: 5 youth reported using alcohol; 2 youth reported using drugs; and 1 youth reported using both alcohol and drugs.[16] Reports of substance use along with the calculated percent change are presented in Table 7 below.

Table 7. Substance Use Among Year 4 Completing Youth

	Number of Youth Using at Intake (N=32)	Number of Youth Using at Exit (N=27)	Percent Change
Alcohol	7	5 (N=29)	-21%
Drugs	8	2	-70%
Both Alcohol and Drugs	4	1	-70%

Summary

Marigold met many of its outcome objectives for Year 4 families who completed FFT. A great majority of completing families showed improvements in family functioning, as illustrated by COM data; almost all youth who completed therapy were enrolled in school or a vocational program at the close of therapy; and a substantial percentage of youth who completed FFT were not using alcohol and/or drugs at the time of program exit.

[16] In every case where the parent suspected the youth was using alcohol and/or drugs, the youth confirmed that they were, in fact, using alcohol and/or drugs. However, in several cases where the youth reported using, the parent reported either that their child was not using or that they did not know if their child was using. Because of the limitation of the parent reported data, only the youth's report of alcohol and/or drug use is presented here.

CHAPTER 5: SUMMARY OF FINDINGS

This chapter summarizes the services provided by Marigold and the outcomes achieved by Marigold families. We highlight the program accomplishments and identify areas for improvement.

Services Provided

Finding 1: The program received a large number of referrals, assessed more than half; and transferred almost a third to therapists for FFT.

During Year 4, the Marigold program received 165 unique referrals from more than 19 sources. The ethnic proportions of the youth referred were similar to the ethnic proportions of the general Umatilla County population. The case manager used the JCP to assess the number of risk factors for 51% of referrals (N=84). After assessment, the case manager connected eligible families (30% of all referrals) with a therapist (N=49). The referral process appears to function smoothly and efficiently.

Finding 2: Although Marigold only provided FFT service to about three-fourths of its objective number of families, the program provided other services to additional families including booster sessions, referrals and case management.

Marigold provided FFT to 76 families during Year 4. Four families served by Marigold in previous years received booster FFT sessions. Moreover, an additional 26 families referred during Year 4 received more appropriate referrals or immediate case management services. However, these 26 families never engaged in Marigold's FFT services.

Finding 3: The program met its objective of maintaining an emphasis on serving girls, as 75% of the youth served during Year 4 were female.

Finding 4: The program served a disproportionately small percentage of Hispanic families.

While county statistics report 16% of the general Umatilla County population is Hispanic, Marigold's service families were only 7% Hispanic. Referral data illuminated that most Hispanic families (85%) were also Spanish-speaking families. Therefore, the smaller percentage of Hispanic families served by Marigold could be due to the presence of a language barrier.

Finding 5: The proportion of families completing FFT was lower than desired.

Just over half of families (56%) who engaged in Marigold completed FFT. Families who completed Marigold's FFT, on average, participated in the program for about 6 months and attended, on average, about 13 sessions. The majority of those families who dropped out did so between the first and fourth session. In most cases, documentation of the reasons why families withdrew from FFT was not available.

Outcomes for Families

Finding 6: For the Marigold Year 4 participants who completed FFT, a great proportion of youth, mothers, fathers, and therapists reported family functioning improvements at exit.

Eighty percent (80%) or more of youth who completed therapy reported improvement in five of six family functioning domains (overall family change, change in communication, change in adolescent behavior, change in parenting skills, and change in family conflict). More than 80% of mothers and fathers completing therapy rated favorable change in all six family functioning domains (including change in parental supervision). Therapists rated 80% or more of families made positive change in five of six domains (all except change in parenting skills).

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

Upon exiting FFT, 94% of youth were attending school or a vocational program.

Finding 8: For those youth who completed FFT, fewer were using alcohol and/or drugs at the end of therapy.

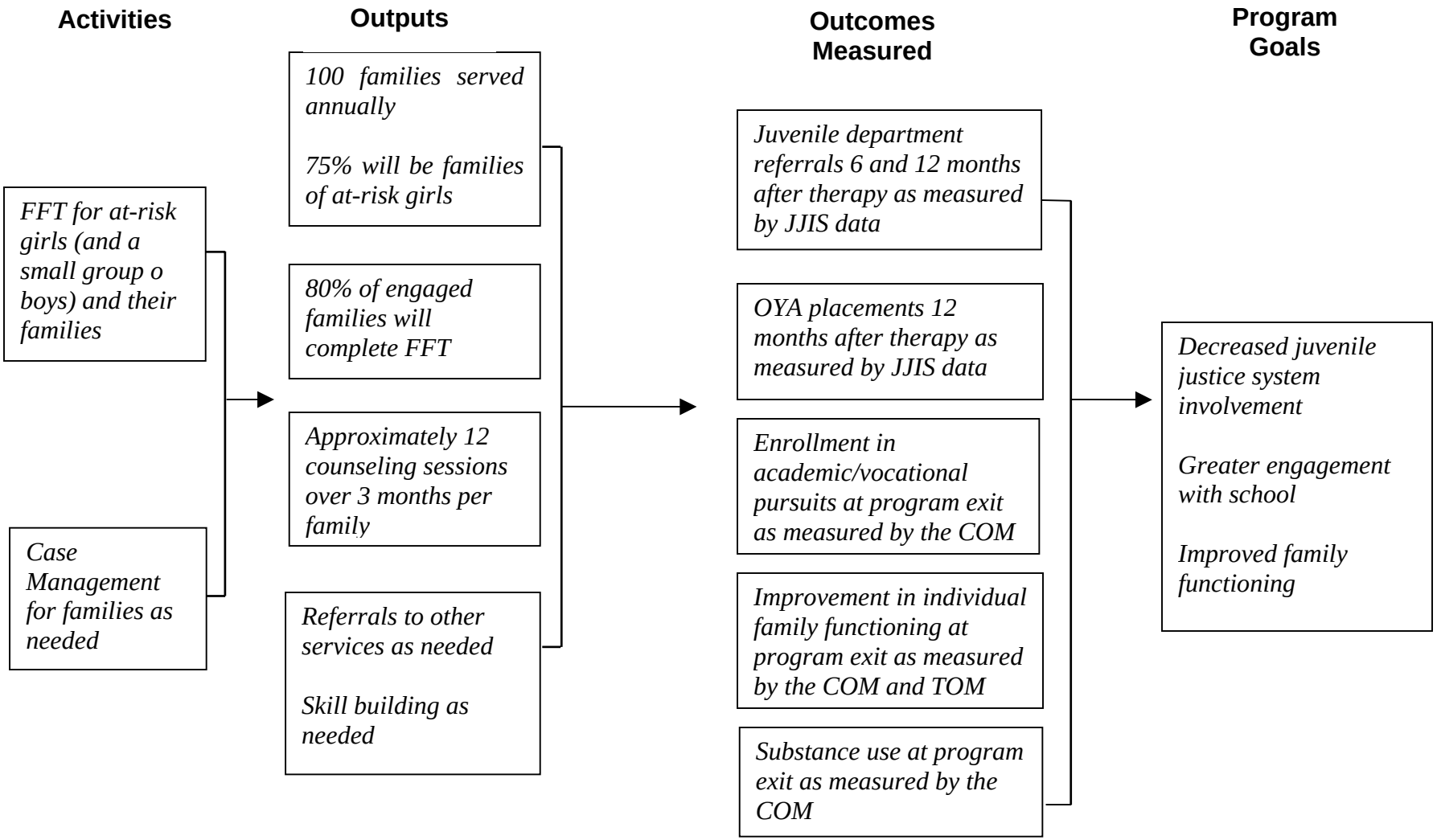
For Year 4 youth who completed therapy, as of program exit (compared to program intake), 21% fewer were using alcohol; 70% fewer were using drugs; and 70% fewer were using both alcohol and drugs.

Conclusion

During Year 4, Marigold achieved many of its objectives. Marigold reached its service delivery objective in terms of the proportion of girls served. However, the program fell short of its service delivery objectives of the number of families receiving FFT and the proportion of families completing therapy. Marigold met many of its outcome objectives in terms of family functioning improvement, school attendance and fewer youth using drugs.

APPENDIX A: MARIGOLD PROGRAM LOGIC MODEL

Marigold Program Logic Model



APPENDIX B: PROGRAM DESCRIPTION

Program Description

By Elisa Doebler-Irvine, Ph.D.

The Marigold Girls program has two major components: Functional Family Therapy and case management. Concurrent with FFT, the Marigold program provides case management services to participating families in accordance with FFT principles. The Case Manager supports the therapy process in accordance with FFT treatment goals. The following is a detailed description of the main program components:

- Functional Family Therapy: FFT is an empirically evaluated, family-based intervention for acting-out youth. The intervention is delivered by family therapists who engage the entire family in skills training in family communication, parenting skills, and conflict management skills in order to change maladaptive behaviors and strengthen positive behaviors. Following the FFT model, the Marigold Girls program therapeutic intervention was designed to last 12 weeks, with approximately one therapy session per week. When necessary, the FFT model allows flexibility and stipulates that therapists assess the optimal "match" to the family's needs in terms of session numbers and frequency and adjust accordingly. Therapists work with families to set treatment goals and if the families' goals are not met within 12 weeks the therapist can continue treatment with the family. Families are given the option of having therapy sessions in their home or at the Homestead offices.

  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. Assessments are completed using the Clinical Services System (CSS), a client tracking and monitoring database that is a required component of implementing Functional Family Therapy. The CSS provides a very structured framework for therapists to record data and features a series of easily generated reports. The CSS requires that the therapist complete a Client Case History at the beginning of services. This form provides information about the family and youth's background and demographics. After each session, the therapist records information about what was done during the session. A report can then be generated that indicates how many sessions the family has had and which phase of treatment they are in.

  The family is asked to complete a Counseling Process Questionnaire (CPQ) at the beginning of every even numbered session. The CPQ measures a variety of therapist behaviors and is intended to assess fidelity to FFT as well as client satisfaction. When Marigold first began services, FFT required that the family and youth complete the Family Assessment Measure III. FFT has since dropped this requirement but Marigold continues to utilize the FAM-III.

  FFT also requires use of the Outcome Questionnaire series (OQ, YOQ, and YOQ-SR) at the initial session and again when counseling is completed. The Family Assessment Measure assesses seven different aspects of family functioning including communication,

involvement, and control. The Outcome Questionnaire is available in both youth and parent versions. The OQ measures clients' progress in therapy focusing on three aspects: (1) symptom distress (anxiety disorders, affective disorders, adjustment disorders, and stress-related illness), (2) interpersonal relationships, and (3) social role performance. The YOQ (completed by parents about the child) and the YOQ-SR (completed by the child about him/herself) assess the child's functioning on a variety of dimensions (intrapersonal distress, somatic, interpersonal relations, critical items, social problems, and behavior dysfunction).

The FFT model consists of three phases: engagement and motivation, behavior change, and generalization. Using the FFT model, therapists determine when families are ready to advance through the FFT phases, with the applied therapeutic interventions determined by the phase.

Phase 1. Engagement and Motivation: The focus of Phase 1 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. This is the most important phase and often the longest for families who demonstrate resistance. During this phase, therapists work to create a shared understanding of the presenting problems and build trust with the family members. A therapeutic alliance is formed between the family and the therapist. The family completes assessment procedures and develops focus. Negativity is reduced and patterns and themes are reframed into positive efforts.

Phase 2. Behavior Change: During Phase 2 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. In this phase the therapist develops and implements individualized change plans that address familial risk and protective factors. The therapist teaches the family new ways to interact and talk to each other. Negative relational sequencing is changed. The therapist is active in instructing modeling and directing session activities with the goal of changing the family's negative relational sequencing. Sequencing behavior is a method used by the therapist to assess what happens and who does what within a family. Sequencing or circular questioning is usually done around the specifics of a presenting problem. Because it is drawn out in a circular fashion it is visually easier to see the context in which behavior occurs. This information is rich in knowledge about all of the participants, the action each took, and the meaning of each participant's behavior.

Phase 3. Generalization: During Phase 3 the therapist helps the family apply positive behavior change techniques to additional situations and potential problems that could arise in the future. The focus shifts to relapse prevention and providing necessary community resources to support change. At this point the therapist becomes more of a case manager and works to assure stabilization of new skills. At closure the family is also offered booster sessions if needed in the future.

Case management: 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 component is designed to work with families that 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 the families until the last phase of the FFT model. As families transition into the final FFT phase, the focus shifts to discussing the families' functioning after they leave the Marigold Girls program. At this point, the therapists determine, with families, whether they have any needs with which the Case Manager can help.

Program Resources

Byrne Funding

The Homestead Marigold Girls program receives Byrne grant funding of $200,000 and provides matching funds of $66,667. During the period July 1, 2003 through June 30, 2004, the program expended $202,434 in federal funds, and $67,477 in match funds. Homestead uses Byrne grant funds for personnel salaries, evaluation activities, and FFT site certification. Homestead contracts with NPC Research, Inc., a Portland-based research and evaluation firm, to serve as the external evaluator and provide process and outcome evaluations of the program and with FFT Inc. for site certification and staff training.

Program Staff

The Homestead Marigold Girls program has a service delivery staff of four persons. There are two FFT therapists, a Case Manager, and a Program Director. The two FFT therapists both have master's degrees. They provide direct service to families using the FFT model and carry caseloads of up to 15 families. The Case Manager provides transition services to families during the third phase and at the completion of their FFT. The Program Director provides overall supervision and also carries a reduced (3-5 family) caseload. The Program Director is designated as the lead therapist and has received training from FFT Inc. to assume a clinical supervision role. Program evaluation services are contracted to NPC Research, Inc.

Collaboration

The key stakeholders for the Marigold Girls program include the Umatilla County Commission on Children and Families, the CARES Team, the Juvenile Services Division, the Oregon Youth Authority, the Oregon Department of Human Services, Umatilla County Health Department, area middle and high schools, Adult and Family Services, and the Confederated Tribes of the Umatilla Indian Reservation. Each of these stakeholders has collaborated with Homestead Youth and Family Services through the development phase of the Marigold Girls program and currently make referrals to the program. The Commission on Children and Families has provided at least $17,500 annually for match funding and several other stakeholders assisted Homestead in planning the new program including the County Juvenile Services Division, the Oregon Youth Authority, and the Oregon Department of Human Services.