Multi-Dimensional Family Therapy

Full Service Partnership Outcomes Report

TABLE OF CONTENTS

Enrollment	5
Discontinuance	5
Demographics	6-7
Length of Stay	8
Outcomes	9-11
Youth Outcome Questionnaire	12-13
Service Detail	14
Appendices	15

Multi-Dimensional Family Therapy Overview

The Multi-Dimensional Family Therapy (MDFT) Full Service Partnership program is an evidence-based practice for youth at risk of placement failure due to externalizing behaviors and/or co-occurring substance abuse issues. Dr. Howard Liddle, Director of the Center for Treatment Research on Adolescent Drug Abuse (CTRADA) at the University of Miami, has developed and refined this intensive family-based treatment model over the past 30 years. Extensive and ongoing clinical research demonstrate effectiveness of the model in engaging and retaining teens and families in treatment, in reducing teen drug use compared with several other state-of-the-art treatments, in improving school functioning, in reducing delinquent behaviors and in improving family functioning. This approach has proven effective for both males and females, in urban as well as rural areas, with young adolescents, as well as with African American and Hispanic youth. MDFT has been successfully transported to a variety of "real life" settings throughout the United States and Europe. In Riverside County, the majority of youth served in MDFT is involved in the juvenile justice system and has been referred through youth probation services. A case vignette is included in this report.

MDFT is a comprehensive treatment program that targets interventions in four domains or dimensions: Individual, Parental, Familial, and Extrafamilial. All four domains are addressed simultaneously throughout the process of therapy in order to counter the cascading effect of multiple factors which contribute to an adolescent's behavioral problems and drug use. Therapists meet with youth and parents individually to enhance motivation for change and create working therapeutic alliances. Family Therapy sessions are held to promote healing in relationships and improve family functioning. Along with the Behavioral Health Specialist, interventions in the Extrafamilial domain include helping families access needed resources (examples include housing, food, and employment), working with school staff, meeting with probation officers, and linking teens to extracurricular activities.

MDFT is an intensive four to six month field–based treatment program which requires staff to have a "do whatever it takes" philosophy in working with youth and their families in this way. It is not unusual for a family to receive 5-6 hours of direct clinical contact in the early stages of treatment per week. A typical day for a Clinical Therapist may include supporting a family at a court hearing in the morning, meeting with a youth and parent at their appointment with their probation officer, visiting a youth at school for an individual session followed by a meeting with school staff, having a session with parents to improve their parenting skills or address the stress or burden of raising a teen, and holding a family therapy session in a home or at a nearby clinic site in the afternoon.

Caseload sizes for Clinical Therapists are small compared to traditional programs due to the intensity of the program and the work required maintaining fidelity to the treatment model. Clinical Therapists plan for weekly therapy sessions and review these plans with their supervisor. Therapy sessions are taped and reviewed on a monthly basis. Each Clinical Therapist participates in live supervision once a month. Here, therapy sessions are observed "in vivo" by the MDFT supervisor and the clinical team with phone in suggestions or other interventions used to enhance therapist's skills and improve session outcomes. Certification is required of each Clinical Therapist which includes successful completion of a mid-term and a final exam as well as successful ratings review of two clinical work samples by MDFT Miami. MDFT supervisors also undergo a rigorous training and certification process which includes review of taped supervisory sessions with Clinical staff by MDFT Miami Trainers. Certifications are renewed annually.

Multi-Dimensional Family Therapy Overview

Five regionally based teams currently provide MDFT services: West, West Expansion, Mid-County, Lake Elsinore and Desert. Full Service Partnership (FSP) outcomes are focused on evaluating changes in a consumer's status relative to several quality of life domains. Baseline histories are obtained at enrollment into the FSP program. Follow-up data is collected on a continuous basis for key life events (e.g. hospitalizations), and is assessed periodically for other select life domains. Outcome reporting is based on comparisons between baseline and post enrollment status and provides a measure of program effectiveness. This report focuses on information to address the following key questions:

- Have hospitalizations and incarcerations reduced?
- Are grades and school attendance improving?
- Has the level of behavioral dysfunction (as measured by the Youth Outcome Questionnaire) been reduced since receiving treatment?

The following report is based on MDFT FSP data collected from each programs' inception in 2006 through June 30, 2015. Two of the regional programs started later than the other three regional programs.

Baseline data for this report is based on responses from each consumer's Partnership Assessment Form (PAF), the history of events for the 12 months before the youth began the FSP. Outcomes data for this report is based on Key Event Tracking (KET) and Three Month Quarterly (3M) assessment forms completed on ImagineNet. Supplemental data from the Youth Outcome Questionnaire (Y-OQ) was collected and submitted from each program individually when available.

Executive Summary

The Multi-Dimensional Family Therapy (MDFT) program has served a large number of youth. The overwhelming majority were identified as having a co-occurring substance abuse issue. Overall, youth participating in MDFT have shown positive outcomes in several areas.

- Since the implementation of MDFT in 2006 through June 30, 2015 a total of 860 youth have been enrolled in the FSP program. During this same period 814 youth were closed from the program which generally lasts about 4-6 months. Overall, 51% of cases closed from an MDFT program were reported to have been successfully discontinued, which is defined as successfully meeting goals such that discontinuance is appropriate. The MDFT program continues to serve youth in five regional programs.
- Latino/Hispanic youth were the most frequently enrolled race/ethnic group followed by Caucasian and African American/Black youth. The proportions of race/ethnic groups served was fairly reflective of the County overall youth population. Over half (54%) of the FSP youth were between the ages of 15 and 16 years old and 26% were 17 or 18 years old. A smaller percentage (20%) of youth age 11-14 were enrolled. The overwhelming majority of MDFT youth were male (75%). A large percentage (69%) of youth were currently on probation at time of program enrollment.
- Overall youth length of stay in the MDFT programs was greater than 90 days. Forty-five percent of youth were in the MDFT program more than 181 days and 40% were in the program 91-180 days.
- Outcomes data has shown positive results with decreases in arrests, psychiatric hospitalizations, emergency interventions, suspensions, and expulsions. Data from school grades and attendance has shown positive results, however some data on grades and attendance is missing.
- Outcome data from youth and parent ratings on the Youth Outcomes Questionnaire (Y-OQ) also showed positive results with significant changes in scores from intake to exit from the program. Not all youth served in the MDFT program had intake and exit scores on the Y-OQ.

Enrollment

The Multi-Dimensional Family Therapy (MDFT) program has enrolled a total of 860 consumers across five MDFT programs. Fifteen consumers were closed and the re-established. The total enrollment through June 30, 2015 is shown in the table below.

Closed Cases thru June 30, 2015

A total of 814 youth closed thru June 30, 2015 for 830 cases. Thirteen youth closed from the program twice as these clients discontinued the program, were re-established to participate a second time, and then closed a second time. In addition, three youth closed in one program and transferred to another.

Successfully closed refers to cases in which the reason for discontinuance was: 'Partner has successfully met goals such that discontinuance is appropriate'. It is important to note that the percent of successful closures is calculated from the total number of cases with a reason for discontinuance noted (N=819) The table below shows the number of cases successfully closing by program with a total of 418 (51%) cases successfully discontinuing.

MDFT Program	Youth Enrolled
Total FSP Enrolled	**860**
Total Closed Cases	**830**
Total Successfully Discontinued	**418 (51%)**

Discontinuance Reasons

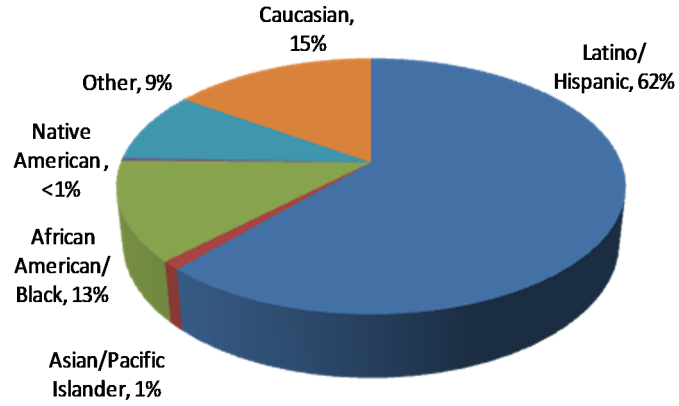
Upon closing from the FSP program a reason for discontinuance is collected. For recorded cases, staff most often reported **Met Goals** as the discontinuance reason. Chose to Discontinue and Unable to Locate were the next most frequently reported reasons, but were a much smaller proportion of closures. Across all closed cases of MDFT with a discontinuance reason, 51% were closed with goals met. A discontinuance reason was not included for five cases, which are not included in the tables below.

MDFT Discontinuance Reason	Number	Percent
Met Goals	**418**	**51%**
Youth/Family Chose to Discontinue	155	19%
Unable to Locate	75	9%
Serving a Jail Sentence	61	7%
Placed in Juvenile Hall/Camp/Ranch	38	5%
Needs Residential Care	35	4%
Moved to Another County/Service Area	31	4%
Target Criteria Not Met	5	1%
Deceased	1	<1%
Total	819	100%

Demographics

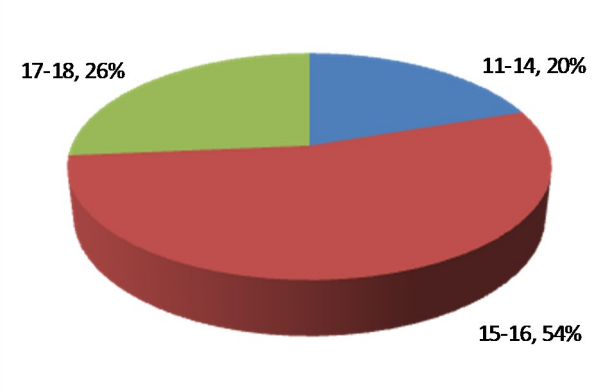
Race / Ethnicity

Overall, the MDFT programs served more Latino/Hispanic youth than any other race/ethnic group. African American/Black youth are somewhat overrepresented at 13% given a 6% representation in the overall County population. Caucasian youth are somewhat underrepresented given that Caucasian youth are 26% of the County population. A much smaller proportion of Native American and Asian/Pacific Islander youth were served, however both groups represent much smaller proportions in the County population.



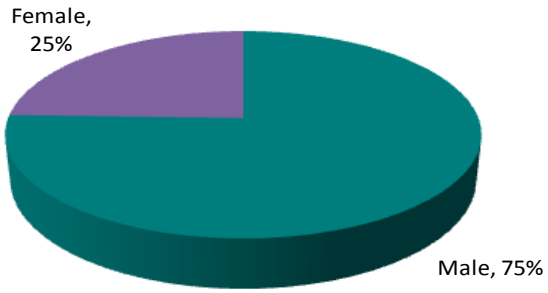
Age

Overall the majority of youth enrolled were between the ages of 15 and 16 years old.



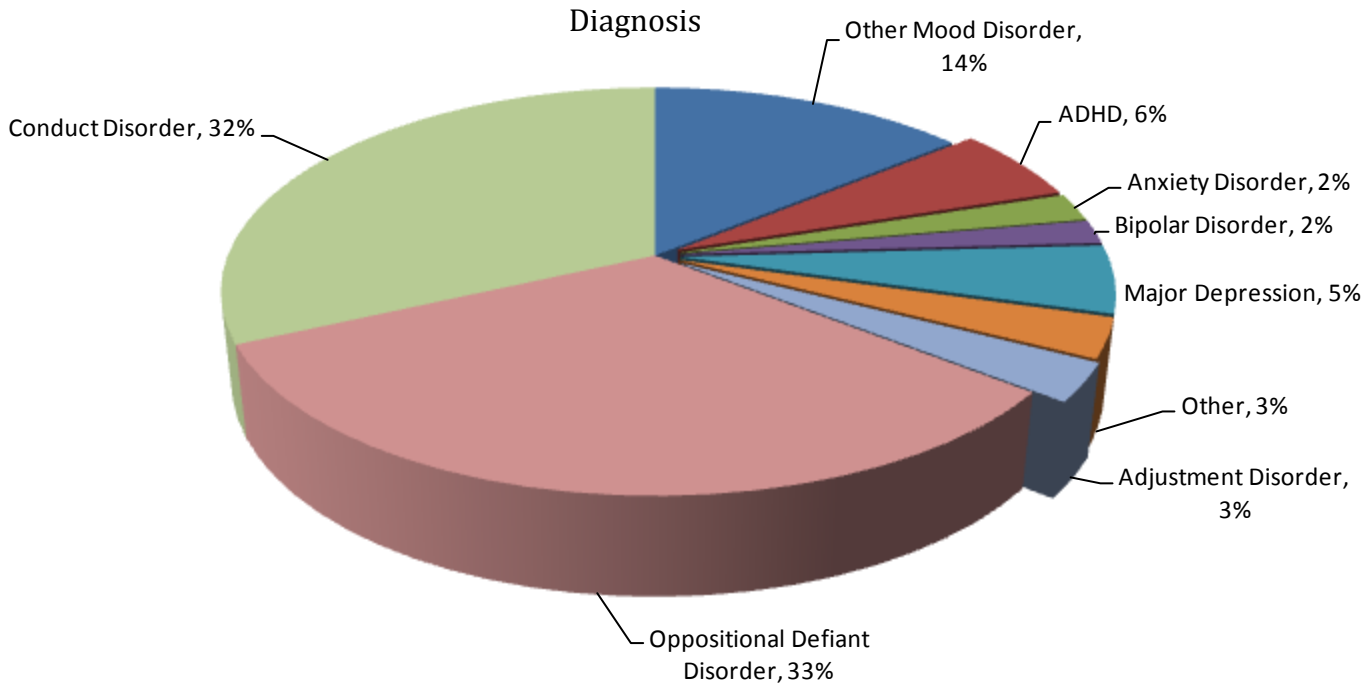
Gender

The overwhelming majority of MDFT FSP youth were Male.



Diagnosis

Most often MDFT youth were diagnosed with either conduct or oppositional defiant disorder.



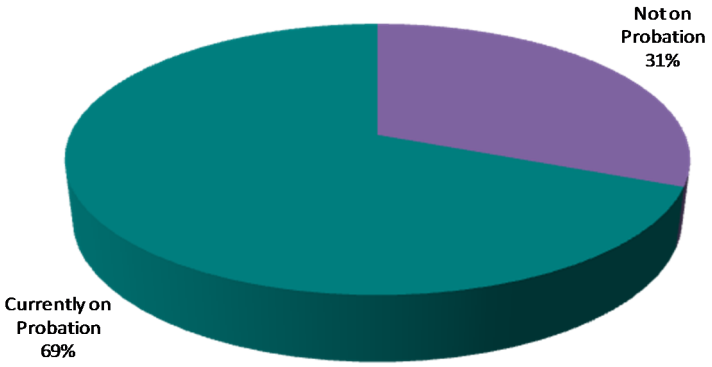
Active Substance Use Problem

Information on co-occurring mental health and substance use problems is collected on the baseline PAF and is also collected quarterly on follow-up. The majority of the youth entering the MDFT FSP program (72%) were reported to have an active co-occurring substance use (SU) problem at enrollment.

Active Co-Occurring Problem	Number SU at enrollment	Percent
Total	621	72%

Legal Status at Enrollment

Information on legal status is collected on the baseline PAF form. The majority of the MDFT youth were reported to be currently on probation. Programs have reported that many of their referrals have been received from youth probation services.



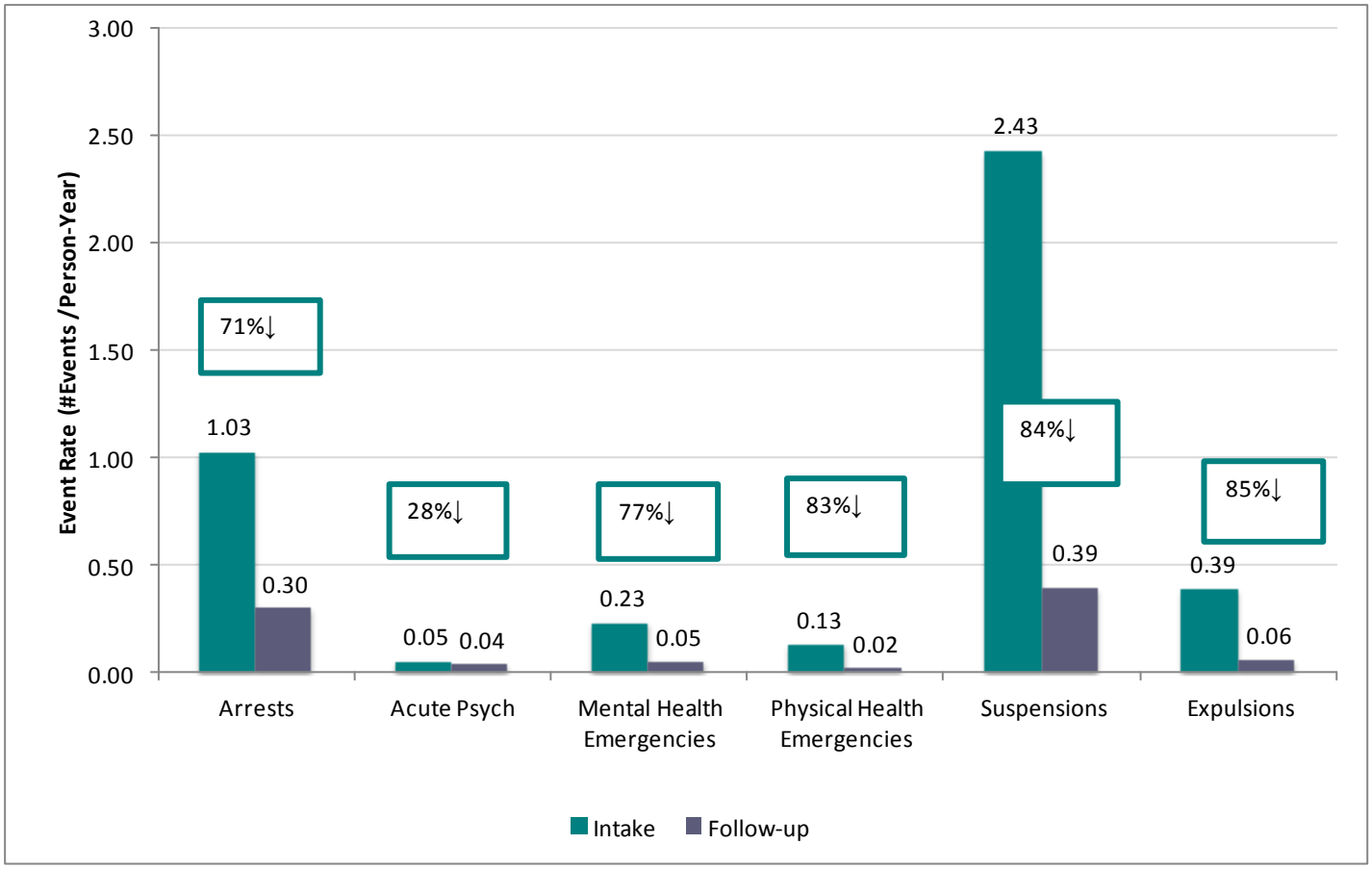
Length of Stay

Consumer length of stay in MDFT is shown in the table below and measures days spent in program from FSP enrollment date to episode close date. Time spent inactive is not included in this report.

Reporting Unit	Time in Partnership	Active	Closed	Closed % of Program Total
MDFT Total	0-60 days	15	60	7%
	61-90 days	6	66	8%
	91-180 days	19	331	40%
	181+ days	**8**	**373**	**45%**
	Total	48	830	100%

Outcomes

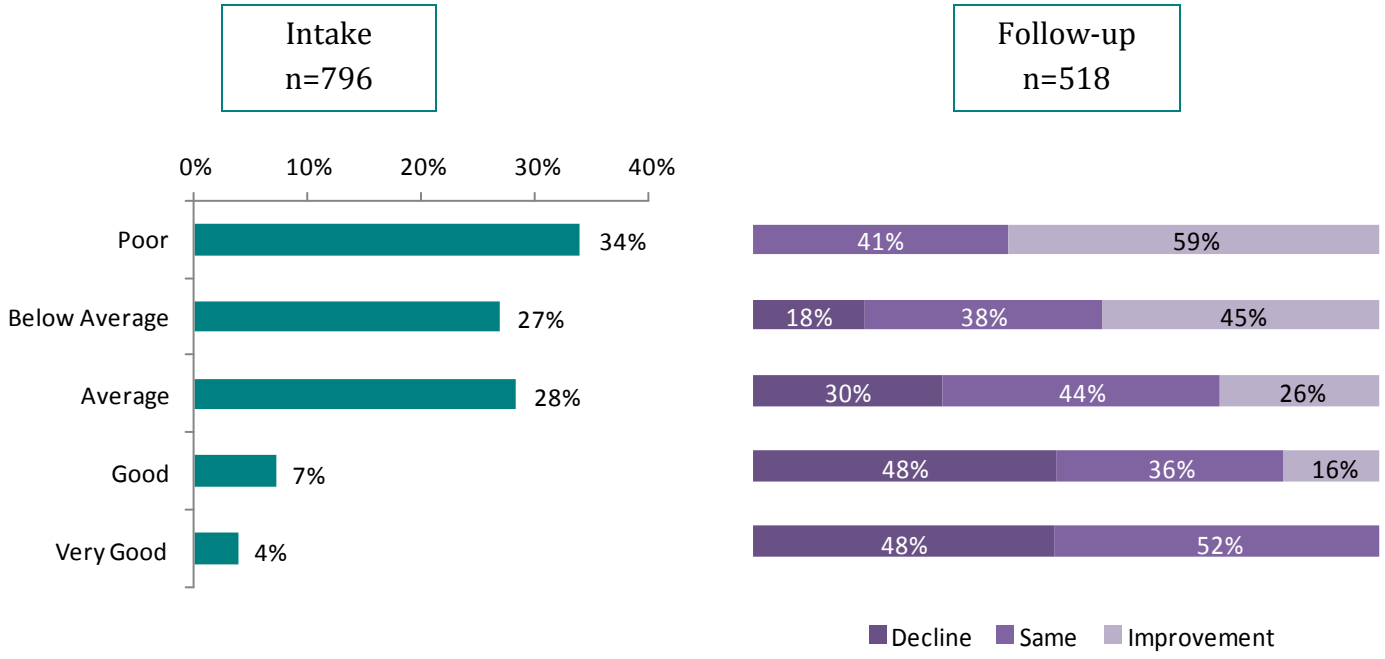
Some of the primary outcomes of interest for youth FSP programs include arrests, psychiatric hospitalizations, emergency room visits, and suspensions and expulsions from school. The outcomes graph presented below includes all five MDFT programs and is a comparison of FSP consumers' baseline year to their time in treatment, based on Key Event Tracking (KET) data collected by the programs. The baseline year is the year prior to FSP enrollment. The graph displays the "number of events per person year," which are not averages per individual. The measurement is based on a sum of the outcome events over the total amount of time in treatment for all youth, which is then averaged for a one year period, in order to compare the rate during baseline to the rate during the treatment period. Actual counts for each type of outcome are provided in the Appendices. Arrests, acute psychiatric visits, mental health emergencies, physical health emergencies, suspensions and expulsions all decreased compared to baseline.



Outcomes

Grades achieved in school are another outcome measure for FSP youth. Intake data reflects the grades reported on the PAF form upon enrollment. Data on grades is recorded quarterly with the first follow-up data collection point 90 days after enrollment in the FSP. Follow-up data on grades used in these analyses is the most currently reported quarterly data. Analysis of school grades at follow-up is done using pre-to post matched pairs and reflects directional change from baseline to follow-up. In some cases follow-up data is missing.

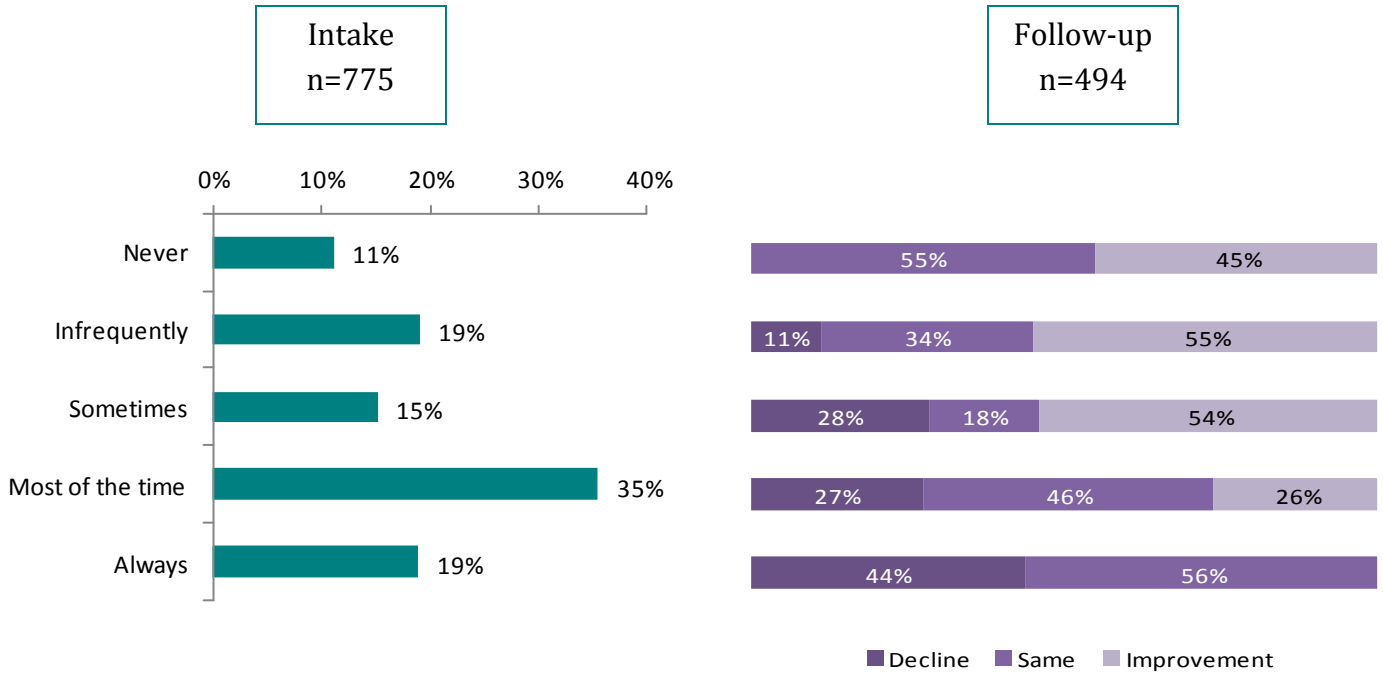
At intake, the largest proportion of consumers were assessed with having below average or poor grades. Improvements were found for 39% of those with follow-up data on school grades. However, 35% of follow-up grade data was missing.



Outcomes

Outcome data is also collected for attendance at school. Attendance data is recorded quarterly with the first collection point 90 days after enrollment in the FSP. Baseline data reflects current school attendance reported on the PAF form. Follow-up data on attendance is the most currently reported quarterly data. Analysis of school attendance at follow-up is done using pre-to post matched pairs and reflects directional change from baseline to follow-up. In some cases follow-up data is missing.

At intake, the largest proportion of youth attended school 'most of the time.' At follow-up, 42% of youth attendance stayed the same and 34% showed improvement. Follow-up data was missing for 36%.



Outcomes: Youth Outcome Questionnaire

In addition to the FSP outcomes required by the state, the MDFT programs also collected data on youth behavior utilizing the Youth Outcome Questionnaire (Y-OQ) which is designed to measure change in functioning. This measure was included in the initial training and program implementation for MDFT, and most programs have continued to use it. At the beginning of program services, parents complete a parent version of the measure (Y-OQ 2.01), and youth complete a youth version of the measure (Y-OQ SR 2.0). The measure is repeated at the conclusion of program services. Data analysis includes (Y-OQ) data where both a pre and post score has been recorded. Not all youth have post scores on the Y-OQ.

Y-OQ Measure: The measure is composed of 64 items that comprise six subscales, a total score is derived from the sum of subscales and is designed to reflect the total amount of distress a youth is experiencing. Subscales include Interpersonal Distress (ID), Somatic (S), Interpersonal Relations (IR), Social Problems (SP), Behavioral Dysfunction (BD), and Critical Items (CI).

- Y-OQ items tap diverse areas of behavioral difficulties as well as including elements of healthy behavior. Values on the Y-OQ total scores can range from –16 to 240. Higher scores are indicative of greater dysfunction.
- Research on normative data for youth in inpatient and outpatient settings and community youth found that youth in inpatient settings and outpatient setting score above a 46 clinical cut-off level. Scores lower than 46 are more reflective of community youth. It has been found that youth ratings on the measure can be lower than parent ratings.

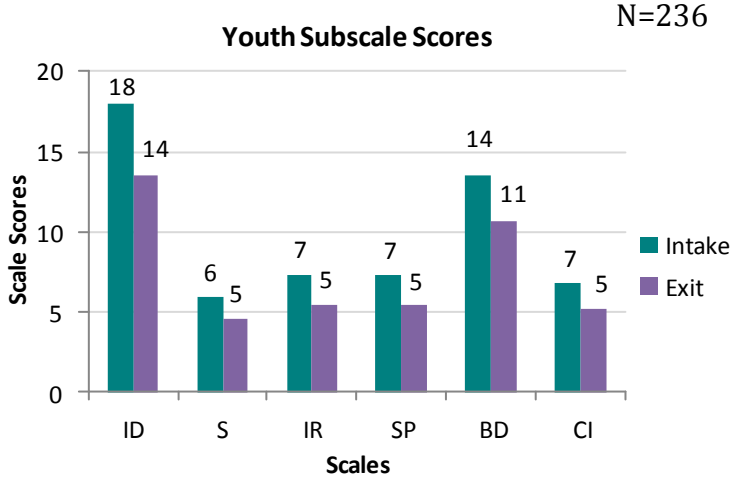
The following table shows the number of child and parent YOQs submitted per MDFT program at intake and exit from the program.

Reporting Unit	Intake	Exit
Child	**500**	**291**
Parent	**460**	**257**

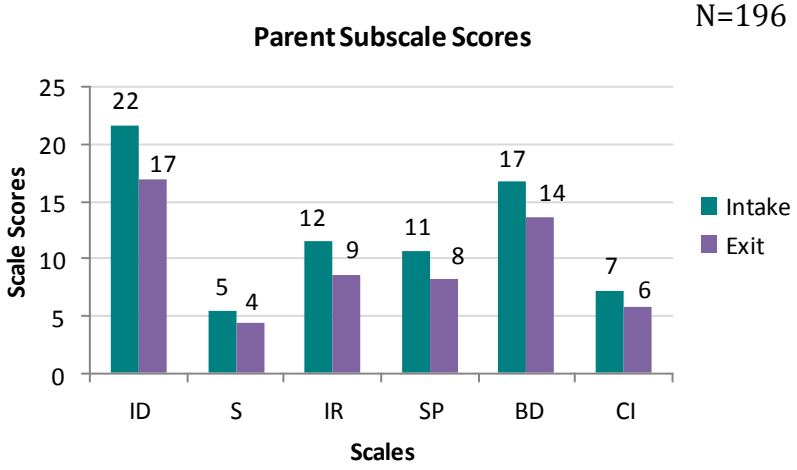
Outcomes: Youth Outcome Questionnaire

N=236

Youth scores from intake to exit decreased across all six subscales.



N=196

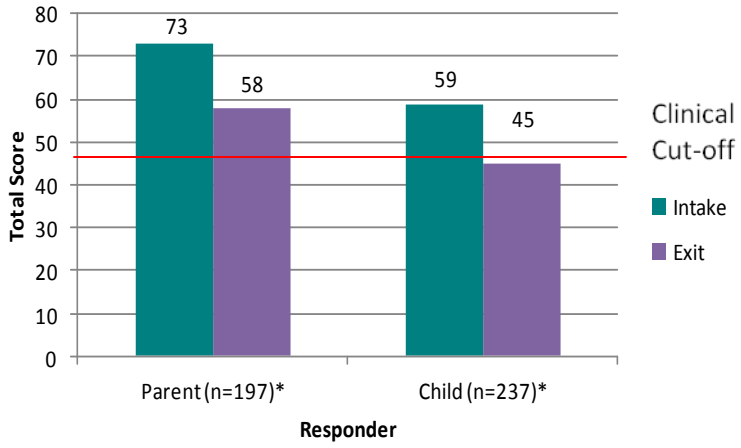


Y-OQ Six Subscales	
ID	Interpersonal distress
S	Somatic
IR	Interpersonal Relations
SP	Social Problems
BD	Behavioral Dysfunction
CI	Critical Items

Parents tended to have higher scores than youth. Parent ratings decreased across all subscales.

Total Scores:

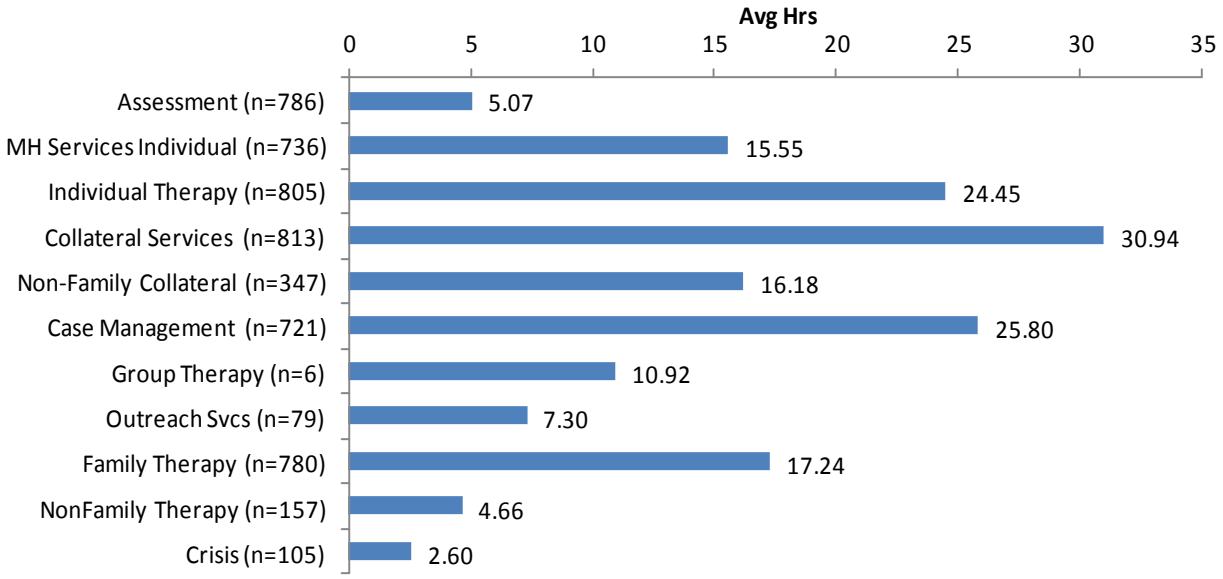
Total scores are derived by summing all the subscales. The average total scores at intake for both the parent and child self-report are above the clinical cut off of 46. At exit, both youth (t(236)=6.707, p=.000) and parent ratings (t(196)=6.792, p=.000) showed statistically significant decreases from intake. The parent report total score dropped by 15 points and the child self-report total score dropped by 14 points. Both decreases are larger than 13 which is considered a reliable clinical change.



* Statistically significant at p< .01

MDFT Service Data All Programs

The average service hours per consumer for each type of service is presented in the following graph. Collateral services and case management had the highest average hours per client.



For each type of service provided the number and percent of enrolled youth that received that type of service and the average number of services per youth served are provided in the table below (number of services provided divided by the number of consumers served).

Type of Service	# of Consumers	% of Consumers	Count of Svcs	Avg # Svcs per Consumers
Assessment	786	91%	1,566	1.99
MH Svcs Individual	736	86%	10,095	13.72
Individual Therapy	805	94%	11,738	14.58
Collateral Services	813	95%	22,871	28.13
Non-Family Collateral	347	40%	5,640	16.25
Case Management	721	84%	15,614	21.66
Group Therapy	6	1%	13	2.17
Outreach Svcs	79	9%	405	5.13
Family Therapy	780	91%	7,335	9.40
NonFamily Therapy	157	18%	402	2.56
Crisis	105	12%	213	2.03

APPENDIX A

Outcomes	Intake Count (n)	Follow-up Count (n)
Arrest (Total)	883 (543)	157 (121)
Acute Psych Hosp (Total)	47 (77)	16 (23)
Mental Health Emergencies (Total)	201 (138)	22 (19)
Physical Health Emergencies (Total)	115 (81)	9 (8)

APPENDIX B

Outcomes	Intake Count (n)	Follow-up Count (n)
Expulsions (Total)	336 (291)	24 (24)
Suspensions (Total)	2,080 (520)	159 (92)