An Evaluation of the Marigold Program, Umatilla County, Oregon

A Byrne Grant

Year 1 Evaluation Report

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September 27, 2002

Acknowledgements

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 girls and their families.

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 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. 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.

Marigold services were designed for Umatilla County at-risk girls between the ages of 11 and 18 who exhibit at least two of the risk factors on the Juvenile Crime Prevention risk screen. Because FFT is a family-based intervention, girls should ideally live at home and have parents or guardians willing to participate in the therapy, or if not, at least have family members and/or guardians willing to participate and work toward reconciliation. Marigold hoped to serve between 100 and 120 girls each year. As expected, the schools and the Juvenile Services Department have been the biggest sources of referrals for the program. All three juvenile counselors at the Juvenile Services Department referred families to Marigold. Many of the school-based referrals came from one source, a community partner who runs a mental health program in several area elementary schools (she primarily referred the older siblings of children that she served in her program). Marigold began accepting families in February 2002. By August 2002, the program had received a total of 40 referrals and 33 families had begun therapy. Preliminary results from the six families that completed therapy by August 2002 indicate that families show a reduction in risk factors and dysfunctional patterns at the close of therapy.

Four broad categories of program strengths emerged from the first year of operation:

- Offering a unique service to Umatilla County Families: The program provided home-based family therapy for girls in a county with few services for girls, and no home-based, family therapy models.

- Fostering strong relations with other agencies: Marigold staff members forged strong relations with other agencies, including the County Juvenile Services Division.

- Providing a cohesive staff and management team: Program staff and management worked as a team to create the program from the ground up.

- Conducting innovative public relations activities: Marigold staff members conducted a variety of public relations activities, including radio and print advertisements and a "Mom and me" event.

As is common with a new program, Marigold faced several challenges during the first year of operation.

- Recruiting adequate numbers of families: Marigold did not reach its recruitment goals during the first year due to difficulty accessing school staff, the low number of girls who become involved with the juvenile justice system, and misconceptions about Homestead services.

- Gaining comfort with FFT: The therapists spent the year learning the FFT model and breaking old habits learned from previous therapeutic models.

- Managing program data: Marigold struggled with the required FFT data collection system, which contained programming errors.

- Providing services to a diverse community: Umatilla County is a rapidly diversifying community, and Marigold faced the issue of how best to provide culturally appropriate services.

- Integrating case management with FFT: Marigold provided case management services to its clients and had to determine how best to integrate case management within the FFT model.

NPC Research offers several recommendations for Marigold. These recommendations are discussed in detail in the full report.

- Marigold should create short-term and long-term recruitment and public relations plans and budget funds appropriately to carry out these plans.

- Use program data to identify FFT areas in which therapists may need additional training.

- Consolidate program data and keep all data in an electronic form conducive for analysis and reporting.

- Explore avenues for offering culturally competent services, including translation services and staff training.

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Chapter 1: Background and Program Description

Marigold program purpose and goals

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

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

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

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 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.

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, described in detail in the program evaluation section below, 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.

Marigold services program design

The following description outlines the Marigold program's original design, including the target population, recruitment and referral plans, staffing and supervision, and therapy and case management. Subsequent chapters of this evaluation report will discuss any variations in this plan as a result of program implementation.

Target population and eligibility criteria

Marigold services were designed for Umatilla County at-risk girls between the ages of 11 and 18 who exhibit at least two of the risk factors on the Juvenile Crime Prevention risk screen. Because FFT is a family-based intervention, girls should ideally live at home and have parents or guardians willing to participate in the therapy, or if not, at least have family members and/or guardians willing to participate and work toward reconciliation. Marigold hoped to serve between 100 and 120 girls each year.

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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.

Recruitment and referrals

Marigold staff members anticipated that the program's referrals would come from two primary sources: the County Juvenile Services Division and local middle and high schools. In addition to these primary sources of referrals, staff members anticipated a smaller number of referrals from social service and mental health agencies, as well as self-referrals. Homestead planned a variety of recruitment efforts to publicize the Marigold program and to generate referrals. Community partners and potential referral agencies were invited to an initial educational meeting featuring a representative from FFT Headquarters; this meeting allowed community partners to learn about the new program, the target population, and the FFT model. In addition, Marigold staff members attended community resource fairs and meetings at partnering agencies, such as the Department of Health Services, Child Protective Services, and the Juvenile Services Division, to make face-to-face contact with individuals in the position to make referrals. Marigold staff members also advertised the program through the local newspaper and radio stations. Finally, staff members created a program brochure and fliers that they distributed to community partners and potential referring agencies, including middle and high schools and the Department of Mental Health.

Staffing and supervision

In December 2001, Homestead hired all Marigold program staff. The program is led by the Clinical Supervisor/Program Director, who also serves as a therapist with a reduced (3–5 family) caseload. Marigold has two full-time master's-level therapist positions designed to each serve between 8 and 12 families at a time. In addition, the program has one case manager.

While the Clinical Supervisor provides the Marigold therapists with supervision and support, the program as a whole receives supervision and oversight from a trained FFT consultant. In addition to the initial on-site FFT training, Marigold staff members are required to take part in weekly conference calls with the FFT consultant. The consultant's role is to reinforce the program model and to provide help, ideas, and examples on how to approach challenging cases.

Therapy and case management

Following the FFT model, Marigold's therapeutic intervention was designed to last 12 weeks, with approximately one therapy session per week. If necessary, the FFT model stipulates that families may receive more frequent sessions early on, with the frequency diminishing over the course of treatment. 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. 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. Families are given the option of having therapy sessions in their home or at the Homestead offices.

The Marigold program also provides case management services to participating families. The case manager position was designed to work with any and all families in the program

that requested help with a variety of needs, including, but not limited to, educational and vocational training and job searches; basic needs assistance such as food, shelter, and clothing assistance; transportation assistance; and childcare assistance. The case manager helps families access these needed services by providing appropriate referrals and helps families navigate the oftentimes-confusing public support and social service systems.

Program evaluation

Byrne Grant evaluation requirements

The Criminal Justice Services Division has required all Byrne Grant awardees to take part in a series of evaluation activities. Each grantee is 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 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.

Homestead has 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. In February 2002, NPC Research completed the logic model for the Marigold program. Throughout the first year of operation, NPC Research has worked with Marigold program staff members to identify and refine expected program outcomes; identify measurement tools; create data collection, management, and analysis procedures; and outline a timeline for evaluation activities in concordance with the CEP requirements. The resultant evaluation design and methodology are reported below.

Evaluation design

NPC Research's evaluation of the Marigold program will involve a process evaluation, outcome monitoring, and, although not required of the Marigold program, an outcome evaluation. During the first year of implementation, evaluation activities focused on

creating the evaluation design, conducting an in-depth process evaluation, and beginning program-monitoring activities. During the second year of the Marigold program, evaluation activities will shift to focus primarily upon program monitoring and the implementation of an outcome evaluation. Finally, during subsequent years, the evaluation will focus on continued outcome monitoring and outcome evaluation.

Process evaluation

The purpose of the Year 1 process evaluation was to monitor program implementation during the first year of operations. The process evaluation can provide the program with valuable information on the extent to which the project was implemented as planned or the extent to which adaptations to the plan were necessary. Furthermore, the study can offer the program feedback on challenges, successful strategies, and recommendations for future operations. The qualitative data gathered from a process study also can be used to explain and elaborate upon quantitative outcome data. Many questions can be answered by a process evaluation. Below is a list of questions addressed by the Year 1 process evaluation:

- Is the program getting the number of referrals it expected? Why or why not?

- What are the characteristics of the youth and families referred to the program (including age, race, risk characteristics, presenting family issues and needs, etc.)? How do these families compare to what staff expected?

- Are families' goals reached in the expected 12-week treatment time period? Why or why not?

- Is the program successfully adhering to the FFT model? Why or why not?

- What are the challenges to successfully implementing the FFT model in this community and with these families?

- Are case management services utilized? What types of needs do families seeking case management have? Are there some needs that cannot be met in this community?

- What have been the most successful aspects of the program during the first year?

- What has presented the largest challenges during the first year?

- Are there any adjustments the program could make in order to improve the quality of services offered to families?

The Year 1 process study consisted of interviews with key informants, a review of program output data, a review of family satisfaction data, and a review of therapist progress notes. Several groups of individuals served as key informants, including all Marigold staff, community partners, the FFT consultant, and the Homestead Executive Director. Each Marigold staff member took part in two interviews with NPC Research staff, one via telephone in early spring, and one in-person interview in the summer. NPC Research interviewed nine community partners in the summer, either via telephone or in-person. These community partners were staff members from referral agencies, including the

juvenile department and school-based mental health services, as well as individuals with a long history of involvement with the juvenile justice and social service communities in Umatilla County. In addition, the FFT consultant assigned to assist the Marigold program and the Homestead Executive Director was interviewed via telephone in the summer.

In addition to the qualitative data gathered through interviews, quantitative data provided valuable information for the process study. NPC analyzed demographic, risk factor, and treatment utilization data for the process study to determine whether the program is serving the target population. In addition, FFT girls and their parents are asked to complete the Counseling Process Questionnaire after the first session and after every third session. This tool provides information about the families' perception of therapy and the FFT process. Finally, each therapist completes a progress report at the close of every therapy session. These reports track the issues that were addressed in the therapy session, the challenges that arose, the current needs of the family, family goals and progress toward those goals, and plans for future therapy sessions. These forms contain a wealth of data, including therapists' perceptions of family progress and the use of FFT constructs and techniques. NPC analyzed these data to describe the utilization of FFT strategies and techniques and therapists' growth and proficiency with the model.

Outcome monitoring

Marigold's outcomes of interest focus on measurable changes in behavior, including increased family and individual functioning, reduced criminal activity, and reduced out-of-home placements. These outcomes will be measured through assessment tools and through JJIS, Oregon's Juvenile Justice Information System. JJIS is a statewide database that includes information on referrals, allegations, resolutions, and severity codes for all youth who are referred to the juvenile justice system.

All programs implementing the FFT model are required to use a series of standardized assessment tools to measure individual and family functioning at the start and at the completion of therapy. These tools include the Outcome Questionnaire, the Family Assessment Measure, the Youth Outcome Questionnaire, and the Problem Oriented Screening Instrument for Teenagers. In addition, at the close of therapy family members complete the Client Outcome Measure. Below is a description of each of these measurement tools.

All girls and their parents complete the Outcome Questionnaire (OQ45.2) at intake and at the close of therapy. This assessment has three subscales: Symptom Distress, Interpersonal Relations, and Social Role. The Symptom Distress subscale consists of items measuring depression and anxiety. The Interpersonal Relations subscale measures satisfaction and problems with personal relationships, including conflict, isolation, and withdrawal. The Social Role scale measures satisfaction and conflict with work, family, and leisure.

All girls and their parents complete the Family Assessment Measure (FAM) at intake and exit. The FAM consists of seven subscales: Task Accomplishment, Role Performance, Communication, Affective Expression, Involvement, Control, and Values and Norms.

Parents complete the Youth Outcome Questionnaire (YOQ2.0), which asks parents to rate their daughters on items grouped into six subscales: Interpersonal Distress, which measures emotional distress; Somatic, which measures physical problems; Interpersonal Relations, which measures relationships with family and friends; Social Problems, which measures aggression and delinquency; Behavioral Problems, which measures inattention, hyperactivity, impulsivity, concentration, and ability to handle frustration; and Critical Items, which measures delusions, suicide, mania, and eating disorders.

Finally, the girls complete the Problem Oriented Screening Instrument for Teenagers (POSIT), which ranks individuals as low, medium, or high risk in ten domains: substance use, physical health, mental health, family relationships, peer relationships, educational status, vocational status, social skills, leisure and recreation, and aggressive behavior/delinquency.

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

Marigold staff members administer the above assessments to all girls and their families and are reporting the scores electronically in a customized FFT database. These data are then transferred to NPC Research for analysis. During Year 1, NPC was able to analyze the intake data for all families served, along with the exit data for the small subset of families that completed therapy by August 2002. In subsequent years, as additional families begin and complete therapy, NPC Research will have a larger pool of assessment score data to use for monitoring purposes. Furthermore, Marigold staff members plan to administer a follow-up survey, modeled on the COM, at 12-month intervals following program involvement. In addition, beginning in the second year of program operation, NPC staff will collect JJIS data on Marigold girls at 12-month intervals after program involvement, to monitor any subsequent criminal activity.

Outcome evaluation

Although the Marigold program is not required to conduct an outcome evaluation, program staff members feel strongly that doing so will further demonstrate the effectiveness of the FFT intervention. Therefore, during the second year of program operation, NPC will establish a partnership with another Eastern Oregon county in order to create a comparison group of girls who meet Marigold's eligibility criteria. It is likely that juvenile department workers will identify these girls. Identification of a partner county and selection of the comparison sample will be the first evaluation activity during Year 2. Once the comparison group is identified, NPC staff, upon receiving informed consent from parents and the girls, will administer the modified COM follow-up survey through telephone interviews with the girls and their parents. NPC will then conduct analysis of the COM follow-up data for both the Marigold families and the comparison sample.

Year 1 Evaluation Report

The remainder of this report documents NPC's process evaluation of Marigold's first year of implementation along with limited outcome data on those families that completed services by August 2002. Chapter 2 describes the families served including demographics, assessment scores, and presenting issues. Chapter 3 outlines the program's utilization of FFT, including therapists' growth, proficiency, and satisfaction with the model; families' satisfaction with therapy; FFT data management; and case management services. Chapter 4 discusses program retention and outcomes, including treatment duration, exit scores, and family progress. The final chapter of the report summarizes the program's successes and challenges, lessons learned, and recommendations for Year 2.

Chapter 2: Families Served

This chapter presents a picture of the girls and families receiving services at Marigold, including information on referral sources, demographic characteristics, assessment scores, and presenting issues.

Referral sources and numbers served

As expected, the schools and the Juvenile Services Department have been the biggest sources of referrals for the program. All three juvenile counselors at the Juvenile Services Department referred families to Marigold. Many of the school-based referrals came from one source, a community partner who runs a mental health program in several area elementary schools (she primarily referred the older siblings of children that she served in her program). The program has received referrals from a variety of other sources, including another Homestead staff member who provides mental health counseling in area middle and high schools; parents who read about the program in the newspaper or heard about it on the radio; a staff member's relative who is a nurse practitioner in the community; and other organizations including the Department of Mental Health and social service agencies. Marigold began accepting families in February 2002. By August 2002, the program had received a total of 40 referrals and 33 families had begun therapy. The initial plans for Marigold called for serving 100–120 families annually, or 50–60 every 6 months. Thus, the program is approximately half way toward its expected enrollment. Chapter 5 includes a discussion of recruitment challenges and suggestions for Year 2.

Demographics

Marigold gathers a variety of demographic information at intake about the families it serves and has collected information on ethnicity from 24 families. Twenty, or 80%, were Caucasian, three were Native Indian, and one was Hispanic. Almost half of the girls were living with their mothers, an additional 19% lived with a mother and stepfather, 11% lived with both parents, and the remaining girls lived with a variety of individuals, including fathers, other relatives, and friends or spouses. Just under one quarter of girls' parents were married and one third were divorced. Three quarters of the families lived in Pendleton, one family lived in Pilot Rock, and the remaining families lived in Hermiston.

The girls ranged in age from 12 to 19, with an average age of 15. Just over 60% of the girls were enrolled in school, and most were in grades 10 through 12. Almost 20% of the girls enrolled in school were in an alternative school, nearly one quarter were failing classes, and one third were receiving D's. Figure 1 illustrates the girls' average grades at intake.

Figure 1. Average Client Grades at Intake
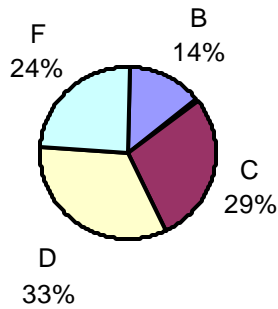
Marigold staff members collect data about substance abuse and criminal activity among the girls and their family members. At intake, 45% of girls had been arrested, 36% had used drugs, and 36% had used alcohol. Substance abuse was common among family members as well: almost one fifth of the girls had family members who had used drugs, nearly one third had family members who had abused alcohol, and almost one third had family members who had been to alcohol or drug treatment. In addition, 30% of the girls have had a family member arrested, one quarter have had a family member on probation, and 13% have had a family member spend time in jail. Figure 2 illustrates these adolescent and family risk factors.

Figure 2. Family Criminal Justice and Substance Abuse History
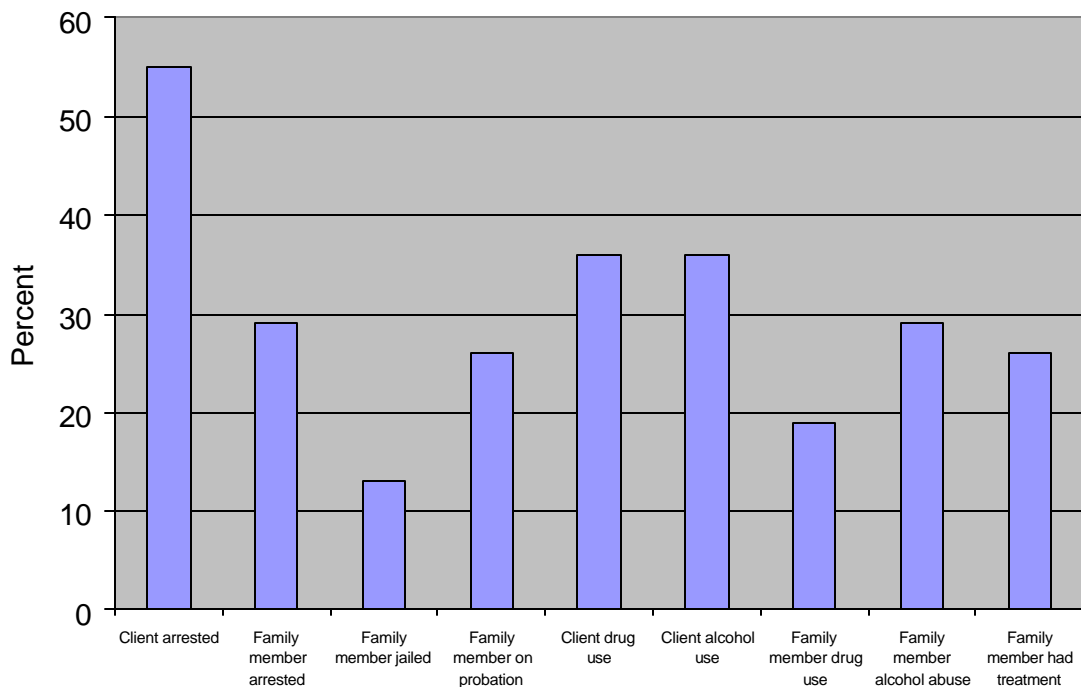
Assessment scores

As described in Chapter 1, the girls and their families complete a range of assessments at intake.[2] These assessments measure individual risks, issues, and behaviors as well as family functioning. The assessment scores of the girls served by Marigold indicate that these girls exhibited multiple risk factors. Scores on the OQ45.2 suggested that the girls and their parents, on average, had high levels of depression and anxiety (as measured by the Symptom Distress subscale), problems with interpersonal relationships (as measured by the Interpersonal Relations subscale), and conflict and isolation within interpersonal relationships (as measured by the Social Role subscale). It should be noted, however, that while on average, mothers and fathers fell into the clinical range on the Interpersonal Relations subscale, the girls themselves did not score in the clinical range on this construct. Table 1 lists the average OQ45 scores for the girls, their mothers, and their fathers.

Table 1. Average OQ45 Scores

Subscale	Adolescent (N=29)	Mother (N=8)	Father (N=4)
Symptom Distress	36*	37*	44*
Interpersonal Relations	14	17*	16*
Social Role	13*	12*	15*

* Scores fall in the clinical range.

In addition, scores on the Family Assessment Measure (FAM) indicated that, on average, the girls and their parents exhibited inappropriate responses to family changes, problems with identifying tasks and solutions, and a tendency for small stresses to cause a crisis (the Task Accomplishment subscale); and insufficient communication, lack of understanding among family members, and an inability to ease confusions (the Communication subscale). In addition, the girls and their fathers displayed either insufficient expression or overly emotional responses (the Affective Expression subscale); the girls displayed either insufficient involvement between family members or intense and extreme involvement among family members (the Involvement subscale); and fathers exhibited power struggles and an inability to adjust to changing life demands (the Control subscale). On average, the girls, their mothers, and their fathers scored in the normal range on the Role Performance subscale. Table 2 displays the average FAM scores for the girls and their parents.

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[2] While the JCP screen was used to determine program eligibility, these scores were not compiled in a format that would have allowed for transfer to the evaluation team. Therefore, only the subsequent assessment measurements are presented here. Chapter 5 includes a recommendation for Year 2 regarding the compilation of JCP scores.

Table 2. Average FAM Scores

Subscale	Adolescent (N=28)	Mother (N=24)	Father (N=9)
Task Accomplishment	63*	61*	61*
Role Performance	59	58	59
Communication	63*	60*	62*
Affective Expression	62*	54	61*
Involvement	67*	56	57
Control	59	58	62*
Values and Norms	56	56	59

* Scores fall in the clinical range.

Mothers and fathers completed the Youth Outcome Questionnaire (YOQ2.0) at intake. Both mothers and fathers on average rated their daughters in the clinical range for all subscales except Interpersonal Relations. Table 3 displays the average YOQ scores for mothers and fathers.

Table 3. Average YOQ2.0 Scores

Subscale	Mother (N=23)	Father (N=10)
Interpersonal Distress	22*	23*
Somatic	7*	6*
Interpersonal Relations	12	10
Social Problems	8*	9*
Behavioral Problems	14*	12
Critical Items	6	6

* Scores fall in the clinical range.

Finally, 22 girls completed the Problem Oriented Screening Instrument for Teenagers (POSIT) at intake. As illustrated in the Figure 3 below, most girls fell into the medium or high risk category for all areas measured on the instrument, including substance use, physical health, mental health, family relationships, peer relationships, educational status, vocational status, social skills, leisure opportunities, and delinquency. However, some areas appear particularly problematic, including mental health, educational status, and social skills, while girls are more likely to be scored as low risk in other areas, most noticeably substance abuse. Slightly more than 70% of the girls scored as low risk in two or more areas, which indicated that while the girls exhibited higher risks in some domains, most girls had other domains that were not problematic.

Figure 3. POSIT Risk Factors at Intake
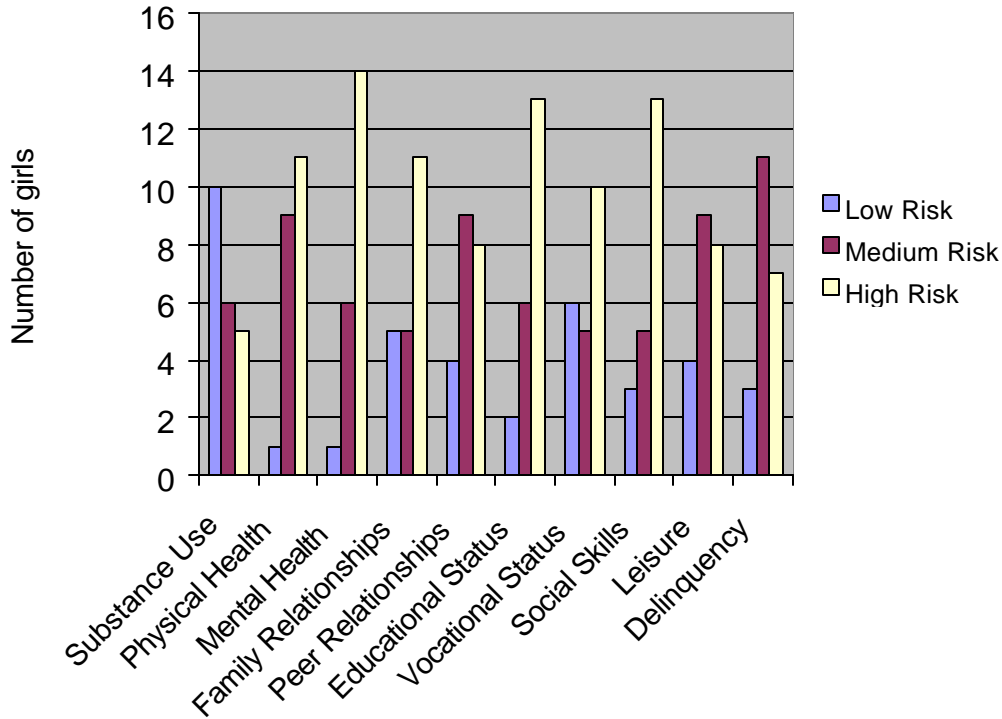
Presenting issues

Therapists included in their case notes descriptions of the families' presenting issues and problems. Several common themes emerged in these descriptions. Two of the most common themes recorded by therapists in their case notes were that of a lack of trust and dysfunctional communication between family members. Many of the families served had parents who did not trust their daughters and daughters who did not trust their parents. Furthermore, many of these families had maladaptive communication patterns. These families were described as having girls who acted out or did not respect parental authority and parents who were unable or unwilling to set boundaries and keep authority over their daughters. In addition, the therapists reported that many of the families were struggling with the girls' alcohol or drug use, depression, and school problems. Finally, many families also were struggling with parental challenges including domestic violence, parental alcohol or drug abuse, psychiatric problems, and parental conflict. Not surprisingly, families often exhibited a combination of these factors; girls' struggles often existed alongside parental challenges.

Chapter 2 summary

Based on the demographics, assessment scores, and presenting issues of the families served by Marigold, the program served its target population. With the exception of one 19-year-old girl, girls were within the expected age range and all exhibited a multitude of risks as indicated by assessment scores and presenting issues. However, as is discussed in more detail in Chapter 5, the program has recruited fewer families than originally anticipated. While noteworthy, the lower-than-anticipated number of families is not unexpected for the first year of operation of a new program.

Chapter 3: Utilization of Functional Family Therapy

As described in Chapter 1, the Marigold program has adopted the FFT model as its therapeutic intervention. The first section of this chapter details the therapists' growth and satisfaction with the FFT model, including training and supervision, commonly used techniques, and the most valuable components of the model. The second section of the chapter describes families' satisfaction with therapy as measured by a self-report questionnaire. The third section of the chapter addresses issues related to FFT data collection and management. The final section of the chapter describes the integration of case management into FFT, the case management services utilized, and families' unmet service needs.

Therapists' growth and satisfaction with FFT

Functional Family Therapy (FFT) was a new therapeutic model for the Marigold staff. All staff members have participated in a training program led by FFT representatives, and staff members receive ongoing supervision via weekly telephone conversations with an FFT consultant. The therapists' training and growth, and the techniques and strategies that they find most useful, are described below.

Training and supervision

In addition to an initial FFT training, Marigold staff members participate each week in an hourly telephone conference with a consultant from FFT. The consultant answers questions from the therapists and helps them reframe issues, strategize, and stay focused on the FFT model. Staff members commented that they can discuss difficult cases with the consultant, and she gives concrete examples of questions the therapists might ask families. While Marigold staff members have appreciated the supervision provided through these weekly telephone conferences, they have gone through a learning process to become proficient with the model.

The therapists have identified several challenges that they have faced when adopting this model. First, as can be expected when learning a new therapeutic method, the therapists had to focus much attention on learning the new model and breaking old habits. For example, one therapist commented that she was accustomed to models that allowed her to be more directed about behavior change with families early on. In addition, the model includes a focus on having families complete therapy in 12 weeks, and one therapist commented that it is challenging to adjust to this fast pace.

The therapists commented about challenges they have faced specifically with the first phase of the model. For example, one therapist felt that it is difficult to have success in the engagement and motivation phase with families who are unwilling to communicate or compromise. Another therapist found it difficult to hold off on all behavior change efforts until Phase 2; she described that she sometimes feels like she as "treading water" as she waits to complete Phase 1.

The therapists have identified two challenges they have faced with Phase 2. First, one therapist has felt that it would be helpful to have additional guidance about when to transition families from Phase 1 to Phase 2. Second, the therapists would also find it helpful to have more "how-to" or "what now" guidance for Phase 2; they would appreciate more concrete examples (one suggested in the form of workbooks or texts) to help guide them through the model.

FFT techniques and strategies

The FFT model, as described in Chapter 1, consists of three phases, and within each phase, the model identifies a set of goals and techniques. As families move through the program, therapists record the strategies and interventions they have used. While too few families have advanced to the third phase to be able to allow for an examination of common Phase 3 techniques, it is possible to identify the strategies used most often in Phase 1 and Phase 2. The focus of Phase 1 is to engage the families in the therapeutic process, and the eight Phase 1 interventions available to the therapists focus on this goal. The Marigold therapists relied heavily on the *relational empathy intervention*: this intervention was used approximately half the time at the first and second therapy sessions, and about a fifth of the time at the subsequent Phase 1 sessions. The other most commonly used Phase 1 technique was the *validation of feelings intervention*: this intervention was used over half the time during the first two sessions, nearly half the time during the third session, and somewhat less in subsequent Phase 1 sessions. The therapists somewhat less frequently used the reframing meaning and the interrupting negative patterns interventions. The therapists rarely, or never, used the other Phase 1 interventions, including focusing conversation, interrupting blaming, separating blame from responsibility, and establishing a relational problem focus.

The focus of Phase 2 is behavior change, and the 10 Phase 2 interventions reflect this aim. The therapists most frequently used the *building communications skills intervention* (used approximately 40% of the time during Phase 2 sessions) and the *skill modeling intervention* (used approximately 20% of the time during Phase 2 sessions) and sometimes used the building parenting skills, reducing negative communication, building problem-solving skills, and contracting for change interventions. The therapists rarely or never used the behavioral aids, response-cost technique, anger management, or organizing community resources interventions.

Therapists also indicated, after each therapy session, their perception of families' progress toward the goals of each phase. Again, too few families have entered the third phase to allow for a meaningful analysis of these data, but data are available for the first two phases. During Phase 1, the therapists recorded progress toward such goals as developing an alliance with the family, reducing blaming, addressing indicators of dropout, and minimizing hopelessness. As would be expected, the therapists' ratings of the level of progress made toward these goals increased as families progressed through Phase 1. Phase 2 goals included, among other things, developing a change plan, skill building, enhancing motivation, building coping abilities, and changing the problem sequence. Unlike the

ratings for Phase 1, the therapists' ratings of progress on these Phase 2 goals remained relatively constant as families progressed through that phase.

During the process study interviews, the therapists discussed what they perceived as the benefits and most useful aspects of the FFT model. Overall the therapists found the model "elegant and precise," and they appreciated the "intentionality" created by the focus on goals. The therapists felt that the model was universal and not better suited to certain types of families and issues; all families could benefit from engagement and behavior change, and the model focused on the unique strengths and dynamics of families as a whole.

The therapists also found benefits to the phase structure; while the therapists have not yet had enough experience with Phase 3 to be able to identify its most useful components, the therapists did have insights into the first two phases. One therapist commented that she appreciated the emphasis in Phase 1 on helping the family reframe the problem in a positive light rather than being confrontational or blaming. Another stated that she particularly liked the reframing technique during Phase 1, as this approach allows the family to break through their blaming patterns, makes the problem relational, and attempts to find meaning in the problem. As the therapists have progressed into Phase 2 they have found this phase to be easier than Phase 1; once families are engaged and motivated, they are open to the behavior change focus of Phase 2. The therapists also commented that the behavior change phase allowed them to bring in techniques and skills they have acquired from other therapy modalities in which they have experience. They appreciated being able to synthesize their previous experiences into their current FFT work.

On the whole, the therapists are satisfied with the FFT model and are eager to perfect their skills and proficiency with the model. The data presented here suggest some areas worthy of further examination, including why some techniques are more widely used than others and why therapists' perception of goal progress does not increase as families progress through Phase 2. It may be that the interventions less frequently used are more difficult, and therefore, as therapists gain comfort with the model their use of these interventions will increase. Alternatively, certain techniques may be more or less appropriate for certain types of families. Chapter 5 includes some recommendations based on an examination of these issues.

Families' satisfaction with FFT

Each family member participating in FFT is asked to complete a survey after the first, and every subsequent third, therapy session. This survey, called the Counseling Process Questionnaire, consists of questions about the therapists' understanding of the family problems and the therapists' efficacy at helping the family. Data from this instrument can provide information about families' satisfaction with the program. Families respond to items using a 7-point Likert scale, with 1 representing completely disagree and 7 representing completely agree. As displayed in Table 4, the girls, their mothers, and their fathers generally agreed that their therapist helped the family deal with its problems. Mothers provided the highest ratings while fathers most often provided the lowest ratings.

Table 4. Selected Items from Counseling Process Questionnaire

Item	Average Response		
	Adolescent	**Mother**	**Father**
Therapist understands our problems	5.3	5.7	5.4
Therapist cares about me	5.5	5.9	5.6
Therapist has necessary skills to help	5.4	5.7	5.3
Therapist and I agree on the problem	5.2	5.7	5.0
Therapist has given me new ways of looking at problems	5.3	5.6	5.0
Therapist is helping us see everyone's role in the problem	5.1	5.6	5.1
Therapist is helping with new ways to deal with adolescent/parent	5.0	5.5	4.8
Therapist has taught new ways of dealing with conflicts	5.2	5.6	4.9
Therapist is helping us talk to each other in different ways	5.2	5.4	5.1
Therapist is helping us plan for potential future problems	5.0	5.4	4.8
Therapist is helping us know how to continue the changes we've made	5.0	5.4	5.0
I am learning new skills in counseling that I can apply elsewhere	5.2	5.2	5.0

The girls, their mothers, and their fathers all agreed most with the statement that their therapist cares about them, which could reflect the therapists' emphasis in Phase 1 on building relational empathy and validating feelings. Not surprisingly, girls and their fathers agreed least with the statement that their therapist is helping them plan for potential future problems; this is the emphasis of Phase 3, and many of the families had not yet reached this phase.

As mentioned above, families complete the CPQ at several points in time throughout their involvement with therapy. These longitudinal data allow for an examination of whether individuals' satisfaction with the program changes over time. Enough individuals have completed the CPQ three times to allow for the calculation of difference scores between the first and third administration. The data in Table 5 indicate that individuals' ratings increased over time on all CPQ items, indicating increased satisfaction. Just as mothers have the highest average scores, they also have the highest average change scores on most items. It is interesting to note that there was no apparent trend or pattern among the change

scores; those areas in which the girls reported the most change are not necessarily the areas in which their mothers or fathers reported the most change. As more families progress through the program it will be possible to examine these data further to corroborate these findings and to test whether the observed increases are statistically significant.

Table 5. Average Change Scores on CPQ Items

Item	Average Change Score Between 1st and 3rd Administration		
	Adolescent	Mother	Father
Therapist understands our problems	0.3	0.4	0.1
Therapist cares about me	0.5	0.4	0.5
Therapist has necessary skills to help	0.2	0.8	0.2
Therapist and I agree on the problem	0.3	0.8	0.2
Therapist has given me new ways of looking at problems	0.2	0.7	0.9
Therapist is helping us see everyone's role in the problem	0.6	0.9	0.5
Therapist is helping with new ways to deal with adolescent/parent	0.1	1.0	0.6
Therapist has taught new ways of dealing with conflicts	0.5	0.8	0.1
Therapist is helping us talk to each other in different ways	0.6	1.0	0.3
Therapist is helping us plan for potential future problems	0.0	0.4	0.2
Therapist is helping us know how to continue the changes we've made	0.4	0.6	0.6
I am learning new skills in counseling that I can apply elsewhere	1.0	0.9	0.5

The CPQ also asks respondents to indicate how family functioning has changed since beginning counseling. Respondents are asked to use an 8-point scale (with 0 representing very bad and 7 representing very good) to indicate both how they felt things were at the start of counseling and how they feel things are currently. Table 6 displays the scores for how family members indicated things were at the start of counseling (data from their first CPQ) and how they felt things were at the time of completing their third CPQ (generally after their sixth counseling session); on average, respondents indicated that family functioning had improved for their families. Mothers and fathers exhibited the largest

increase in scores, which could be explained by the fact that they displayed lower scores start of counseling than did the girls.

Table 6. CPQ ratings of family functioning

Respondent	How things were at start of counseling	How things are now	Change score
Adolescent	3.4	5.2	1.8
Mother	3.0	5.6	2.6
Father	2.9	5.3	2.4

Finally, the CPQ asks respondents to indicate how sure they are that things will get better in their family. Table 7 displays the percent of respondents indicating that they are somewhat or very sure, a little sure, or not at all sure that things will improve for their family. A minority of the adolescents and their parents are not at all sure that things will get better for their families, while a majority of respondents are a little, somewhat, or very sure that things will improve.

Table 7. How sure families are that things will get better

Respondent	Somewhat or very sure	A little sure	Not at all sure
Adolescent	30%	41%	30%
Mother	16%	50%	35%
Father	32%	47%	21%

The CPQ data indicated that, overall, families believed that their FFT therapist was helping them work through their problems, and furthermore, respondents became more satisfied with their therapy as they progressed through counseling. In addition, respondents indicated that their family situation improved from the start of counseling, and most were at least a little sure that things will get better for their families. These results suggest that, on the whole, families were satisfied with the FFT therapy they were receiving at Marigold.

FFT data collection and management

Comprehensive assessments and detailed case notes are an integral component of the FFT model. Families complete standardized assessment instruments, as described in Chapter 2, at program intake and exit, and complete the CPQ periodically throughout therapy. Therapists complete detailed client progress reports following each session and complete an outcome measure for each family upon program completion. The discussion below summarizes the program staff's perceptions of the required data collection and describes the data management procedures and challenges.

Perceptions of the required FFT data collection

Despite some initial skepticism about the required quantity of data collection, the therapists all found the assessment measures completed by families to be helpful, however, all commented that they rely first and foremost on what the families think the pressing issues are and their own professional perceptions of the families, and not just on what the assessment scores indicate. One therapist believed that often the assessment scores simply confirm what she could see for herself in the family; she did not feel that the assessments provided any new or unique information from what she gathers through her conversations with the family. Another therapist found the POSIT the most useful measure because it can identify problem areas for the girls and was therefore helpful for case planning. Another believed that administering the assessments at the first session with the family served to "jump-start" therapy by bringing issues to the forefront immediately that otherwise may take some time to uncover. One therapist also explained that the CPQ, which allows families to express their satisfaction with various facets of the therapy, was a useful tool for identifying areas where she would like to improve. The therapists commented that they have learned how to present the assessments to the families so that families are willing to participate; families were made aware that the first session focuses on the paperwork and were told that the assessment scores will help the therapists with their case planning.

As mentioned above, therapists completed detailed FFT client progress reports at the close of each session. The case notes required the therapists to detail the interventions used in each session, the important goals for each session, and the progress made on these goals, among other items. The therapists felt that completing the client progress reports helped them stay focused on the FFT model, helped with planning future sessions, and in general helped them stay focused and directed. One of the therapists described the process of completing and reviewing client progress reports as a form of "mini-supervision," which had been especially helpful because Marigold does not have an on-site FFT supervisor. However, one therapist noted that completing the client progress reports is time consuming, and another expressed difficulty with understanding the focus of some of the questions on the reports.

Data management strategies

All of the required FFT data were entered into a customized database, called the Clinical Services System (CSS), created by FFT. Therapists calculated the assessment scores and entered these into the CSS, and the therapists completed the client progress reports electronically in this same database. The CSS was designed to capture all information about the participating families in one centralized location; the database allows for the entry of all contacts (including sessions and telephone conversations) between the program and its families, along with all the therapeutic information. However, Marigold staff members have had difficulties with the CSS; the database sometimes made double entries and other errors that distorted or misrepresented the data. Marigold has requested technical assistance from FFT headquarters with these problems, but thus far no resolution has been found. Perhaps partly as a result of these problems, staff members did not rely entirely upon the CSS for their data management needs. Specifically, staff members did not

consistently enter data about contacts (e.g., phone calls or home visits) between the program and the families. While some of this information was entered into CSS, a majority of these data were collected on paper tracking forms that were compiled and stored by the case manager. In addition, data about the referral sources for each family were kept only in paper format. Furthermore, the program collected some information that is not required by FFT, and therefore, there was no avenue for entering these data, including the JCP risk screen scores and detailed information about the case management services provided (summarized case management information is included in the CSS, but the case manager had a separate system for keeping detailed notes on her services). Chapter 5 includes some recommendations about data collection and management that the program may wish to consider in Year 2.

Case management services

The Marigold program design called for case management services in combination with FFT. Approximately 75% of families utilized some form of case management. Below is a discussion of how case management services were integrated into the FFT model, the types of case management services utilized, and families' service needs that could not be met through case management.

Integration of case management into the FFT model

When the Marigold program began operations, the case manager took an active role with families whenever they needed her. This structure meant that families could access case management services as early in the FFT process as they wished. However, program staff members soon learned that the FFT model does not condone the use of case management throughout the therapeutic process due to the fear that if the program gives too much case management help too soon, families might drop out once their resource needs are met without having addressed the underlying issues that brought them to therapy. Marigold therefore had some difficulty in reconciling the requirements for their Byrne grant, for which they had promised to offer case management, with the requirements of the FFT model, which discourages case management services. While for the first few months the case manager was proactive and eager to help families early on, Marigold then decided to limit case management services somewhat. Marigold reached a compromise by adjusting its case management services so that the case manager introduces herself to the families early in the therapy process but does not start servicing families until the last phase of the model.

However, Marigold and FFT Headquarters have come to an agreement that occasionally case management will be provided early in the therapeutic process, for example, when a family is in a crisis and its basic needs, including housing, food, and adequate resources for daily living, are not being met. The case manager will help these families in crisis with the goal of stabilizing the family enough so that they can focus on their therapy.

The Marigold case manager relied on the therapists to determine when a family was in need of case management services. As families transition into the final FFT phase, the focus shifts to discussing the families' functioning after they leave Marigold. This was a

logical time for therapists to determine with families whether they have any needs with which the case manager can help. At this stage, the case manager helped families with a variety of issues, as described in the following section.

Types of Case Management Services

The data indicated that 75% of Marigold families receive case management services. The Marigold program connected families to a variety of resources. They included, but were not limited to, volunteer opportunities, employment services, education, and transportation.

The case manager connected families with employment services and other work-related activities such as volunteering opportunities for the girls. Volunteering opportunities have included community gardens and senior centers, and girls were offered these opportunities in order to have positive activities in which they could gain skills and experience. The case manager sometimes transported family members to these services if there was no other transportation available. Interviews with key stakeholders indicated that there is a lack of public transportation resources in Umatilla County, and that this limitation has been an obstacle in connecting families to resources. Marigold has covered the cost of taxis on a limited basis. However, program staff members wanted families to learn to find their own solutions to their transportation needs, so the program offered only limited transportation assistance and instead helped families problem solve about other transportation possibilities.

The Marigold case manager also connected families to educational resources. The case manager connected families with tutoring resources, GED classes, college enrollment resources, and Head Start. Additionally, the case manager connected families to services for testing for learning disabilities. One example of the educational help the case manager provided was the case of a 17-year-old with a baby who wanted to complete high school. The case manager connected her to services and childcare for the baby as well as helped her with school enrollment and other educational services.

The case manager helped families with a variety of additional needs, including nutrition and Head Start services for younger siblings, family planning resources, childcare, and anger management. Aside from occasionally offering transportation, for the most part Marigold provided families with referrals to services rather than providing services directly. Those families that need case management services on average receive two referrals from the case manager.

Unmet Family Needs

Key stakeholders reported that transportation was the most critical limited resource for families. Interviews indicated that like many rural areas, there is inadequate public transportation in Umatilla County. This limitation created problems for families without cars, who consequently had a difficult time getting around to various service providers. Other important unmet needs included recreational activities for teens, a Spanish interpreter, and a need for alcohol and drug services tailored to teens. In addition, while interviews indicated that generally there were services available to help families meet their

basic needs, there were a limited number of these services. Therefore, once a family had already tapped those resources it is challenging to come up with new options.

Chapter 3 summary

Marigold staff members have spent the first year of program operations learning the FFT model and beginning to provide services to families. Staff members have been enthusiastic about the model and the services they have provided while they have dealt with the inevitable learning curves and challenges that arise when implementing a new program. Chapter 4 describes outcomes for those families who have completed FFT, and the final chapter of this report highlights the accomplishments and challenges of Marigold's use of FFT and offers suggestions for Year 2.

Chapter 4: FFT Retention and Outcomes

The Marigold program collects a variety of information on the families it serves, including assessments completed at intake (as described in Chapter 2), documentation of the number and frequency of therapy sessions and other contacts, and assessment and outcome measurements taken at program exit. As mandated by the FFT model, families, upon exiting the program, complete the same assessment measures they completed at program intake, along with a client outcome measure. In addition, therapists also complete an outcome measure on the families. This chapter presents information about family retention, as measured by the documentation of number and frequency of therapy sessions, as well as outcome data on the eight families who completed some or all of the exit assessments by August 2002. In future years, Marigold will have close-of-therapy outcome data on a larger number of families and also will collect follow-up data on families annually.

Retention

One tenet of the FFT model is an emphasis on engaging and retaining families. Marigold has been successful in getting referred families to begin therapy; indeed, families often are eager for help and willing to try the program. Only two referred families have declined to come in for the initial intake interview. Once families begin therapy, the first phase of FFT focuses on engaging the family and minimizing attrition. Marigold's data indicate that seven families began therapy but have not had an appointment in at least 2 months. Most of these families completed four or five sessions, while one completed only two and one completed eight. It is not clear from the data whether some of these families successfully completed therapy but have not completed the required paperwork necessary to exit the program, or whether these families represent attrition from the program.

Another principle of FFT is that services should be completed in approximately 3 months. In that time period, therapists should be able to work through the three phases with the families and families should reach their goals for therapy. Marigold families completed therapy within this expected timeframe: of the eight Marigold families that have completed some or all of the exit paperwork by August 2002, three families completed the program in 2 months, two families completed in 3 months, and one family completed in just over 3 months.

Outcomes for families

At the close of therapy, girls and their families completed each of the assessment instruments once again. As of August 2002, only eight girls and their parents had completed some, or all, of the post-therapy assessments. However, data from these eight families indicated that individual and family functioning increased in several domains.

As would be hoped, average scores for the girls on two of the OQ45 subscales were somewhat lower at the close of therapy than at program intake: scores on the Symptom Distress subscale decreased on average by over five points, and scores on the Social Role subscale decreased an average of 1.5 points.

The families showed some improvement on the FAM at program exit as well. As described in Chapter 2, at intake fathers on average scored in the *clinical* range on four of the subscales; at program exit their average scores on these four subscales dropped into the *normal* range. Furthermore, at program entry, at least 50% of the fathers fell into the *clinical* range on all subscales, and at program exit, all fathers fell in the *normal* range on five of the subscales, and 80% of the fathers fell in the *normal* range on the two remaining subscales. Mothers, on average, scored in the *clinical* range on two subscales at program entry, and their scores on these subscales also dropped into the *normal* range at program exit. At program entry, at least 67% of the mothers scored in the *clinical* range on all subscales, and at program exit, at least 67% of the mothers scored in the *normal* range on all subscales. On average, girls scored in the *clinical* range on four subscales at program entry and only one of these scores dropped into the *normal* range at program exit. However, while at program entry a majority of the girls fell in the *clinical* range on three subscales (Task Accomplishment, Communication, and Affective Expression), at program exit a majority of the girls fell in the *normal* range on these subscales.

Mothers and fathers completed the YOQ at intake; mothers scored in the *clinical* range on four subscales and fathers scored in the *clinical* range on three subscales. At program exit, with the exception of mother's scores on the Somatic subscale, all scores had moved into the *normal* range. It is interesting to note that fathers' scores dropped more than mothers' scores on all subscales. Figure 4 displays the program entry and exit scores on each of these four subscales for the five mothers and four fathers who completed both the intake and exit assessments.

Figure 4. YOQ Scores Drop at Program Exit
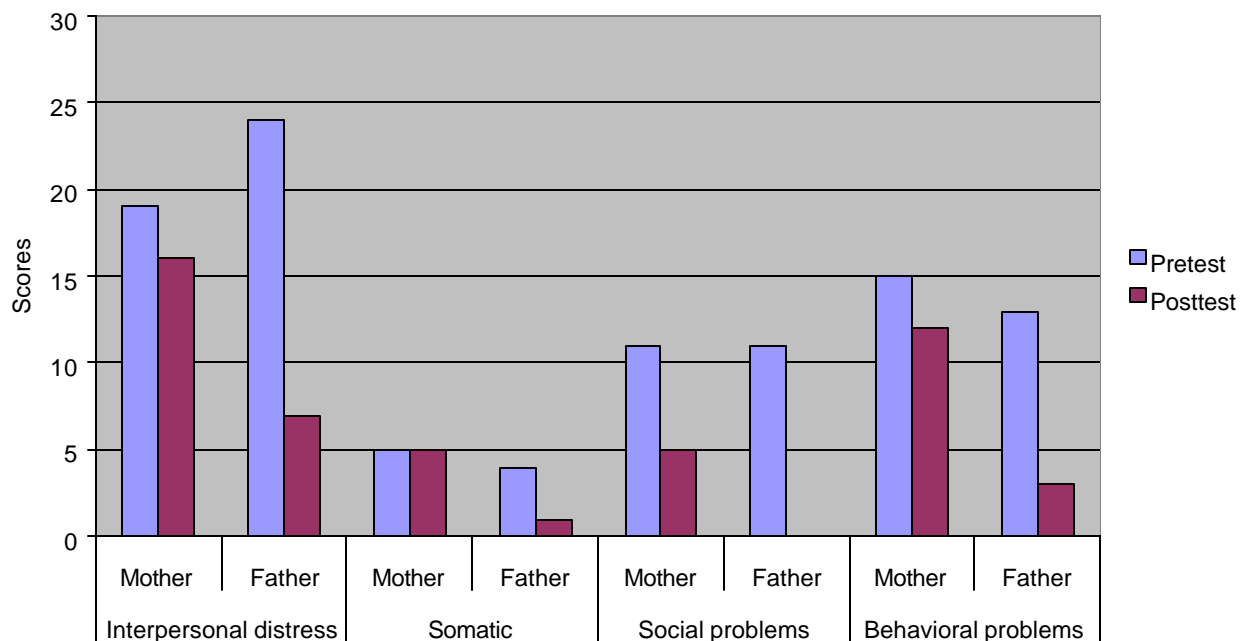
The girls completed the POSIT at program intake and exit. Fewer girls scored as high risk at program exit on the substance abuse, physical health, mental health, family relationships, peer relationships, educational status, social skills, and aggressive behavior subscales. Figure 5 below displays the percent of girls scoring as high risk at program intake and exit for the six girls who completed both assessments.

Figure 5. Percent of Girls Scoring as High Risk
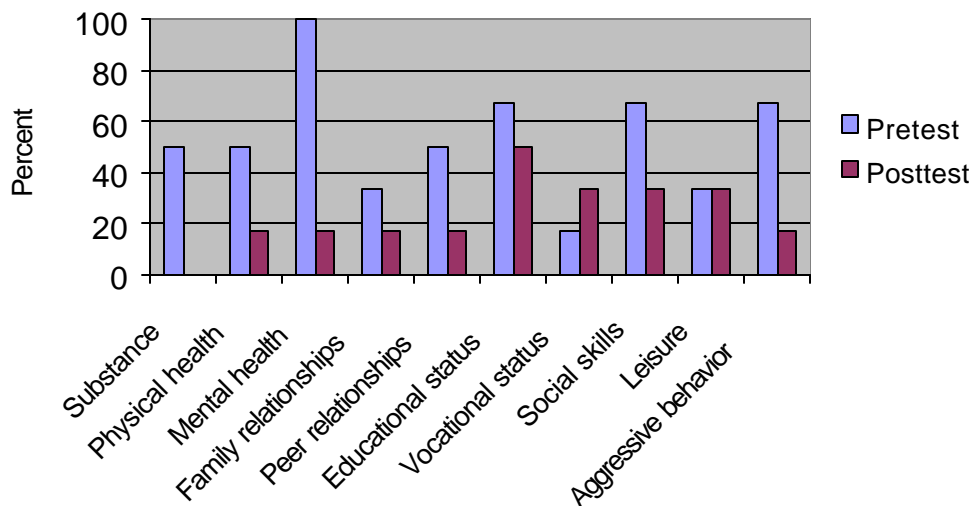
In addition to completing the assessments, girls and their parents provided information about their perceptions of how family functioning changed since counseling began through the Client Outcome Measure (COM), which was administered at program exit. Seven girls, six mothers, and four fathers completed this measure. Individuals were asked to indicate how much change there had been in the family, in the family's communication skills, in the girl's behavior, in parenting skills, in parents' supervision ability, and in conflict level since intake. Most individuals indicated that things were "only a little better" or "somewhat better" in each of these domains.

Therapists completed their own version of this instrument at program intake and at program exit. The therapist version provided information about the therapists' perception of family relationships, punishments, and rewards. Therapists have completed the intake and exit questionnaire for six families. While the therapists' responses on the pre-test and post-test were largely similar on most items, several items did show interesting patterns. At program entry, therapists indicated that two of these girls usually obey their parents and four sometimes obey, whereas at program exit therapists report that four usually obey and only two sometimes obey their parents. In addition, at program intake therapists reported that four of these families did not use appropriate punishment, whereas at program exit therapists report that four of the families do use appropriate punishment. Therapists' responses to the other survey items show little or no change between pre-test and post-test.

However, these families entered therapy with some significant challenges, and therefore even modest improvements in the families' and therapists' perceptions of their functioning is noteworthy. It will be interesting to follow families past their involvement in FFT to determine whether their ratings of family functioning improve over time.

In addition to these quantitative assessments of outcomes, the interview respondents provided some information about family progress as well. One therapist noted that one girl greatly improved communication with her mother after just several sessions, and another believed that having families return for subsequent sessions is a sign that they are making positive changes in their lives. Three different individuals who have referred girls to the program have gotten positive feedback from these girls; the girls reported that they are getting what they had hoped out of the program. The therapists emphasized that they would not exit a family if it had not reached its goals, although they explained that these families have multiple issues and the goals for therapy may be modest. For example, one therapist commented that it is a success if at the close of therapy a girl is staying out of trouble, even if there is still fighting in the family.

Chapter 4 summary

Preliminary outcome data from a small subset of families indicated that girls and their parents show positive changes on the assessment scores. Scores on the Client Outcome Measure indicated only moderate improvements in perceptions of family functioning. As more families progress through the program, it will be possible to examine whether the results from additional families mirror the results obtained from the first six families to complete the program, and whether any observed changes are statistically significant.

Chapter 5: Program Successes, Challenges, and Recommendations for Year 2

The previous chapters of this report have described the first year of program operations at Marigold, including the families served, the program's use of the FFT model, and family outcomes. This final chapter summarizes the program successes and challenges identified by staff, key stakeholders, and program data. In addition, the chapter concludes with recommendations for Year 2 operations.

Program successes

Program staff and key stakeholders identified what they considered to be the strengths and successes of the Marigold program. These strengths fell into four broad categories: the services offered by the program, the program's reputation and relations with other agencies, program staff and management, and innovative public relations efforts. Each of these areas is described in more detail below.

Offering a unique service to Umatilla County families

Staff and key stakeholders alike believed that the biggest strength of the Marigold program was that it offered a much-needed service for Umatilla County families. No other program in the county offers family-based therapy for girls, and respondents all agreed that such a service was desperately needed. One stakeholder, who has worked in the community for over seven years, said that in that time she has been aware of only one other service offered specifically for girls. Another respondent emphasized that Marigold's ability to serve youth on probation was important; some other services in the community exclude young people involved with the juvenile justice system.[3]

Furthermore, respondents indicated that Marigold was far more accessible to families than other services. The program's ability to provide therapy sessions in the home and during evening and weekend hours is unique; other services for Umatilla County families do not often offer flexible hours and home-based services. Respondents noted that in-home therapy sessions are especially valuable for families without cars or other transportation options. Finally, respondents noted that the program was free of charge, which allowed families of all income levels to benefit from the service.

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[3] Some respondents explained that they thought FFT services are needed for boys as well, and explained that the program was attempting to meet that need by serving a small number of boys and their families. A male Homestead staff member has been trained in the FFT model and was staffing these cases, but because no Byrne grant funds supported this service, the data generated on these cases has not been included in this evaluation.

Fostering strong relations with other agencies

The key stakeholders were unanimous in their agreement that Homestead had done a great job in educating their agencies about the new Marigold program and the FFT model. One respondent joked that she had learned so much about FFT that she thought she could conduct one of Marigold's informational sessions herself. Marigold held an informational meeting at a local hotel shortly after program staff members were hired. This meeting, which included a presentation on FFT by a representative from FFT headquarters, allowed representatives from social service and juvenile justice agencies to learn about the therapeutic model and the types of families that Marigold hoped to serve. In addition, program staff members paid visits to staff at other agencies, including the juvenile department, mental health, and social services, to introduce themselves and the program. Key stakeholders felt that these efforts have resulted in a service community that is well informed about Marigold's services.

Marigold has benefited from the relationships that Homestead has with other agencies in the community. Key stakeholders noted that Homestead is a "known quantity," and that Marigold's program director, whom they know through her other work at Homestead, had an "impeccable" reputation. Stakeholders expressed respect and trust for Homestead's programs and staff, and this environment, combined with the education efforts described above, resulted in positive feelings about the Marigold program. Furthermore, Homestead included representatives from many agencies in the initial planning for Marigold, as described in Chapter 1. Thus, the program was responsive to the suggestions of these stakeholders and the needs of the community. As a result, these individuals, and others at their agencies, felt a connection to the program.

Finally, those agency representatives who have made referrals to Marigold explained that their respect for the program was bolstered by the ease and professionalism of the referral process. Respondents said that they received prompt replies to their calls and Marigold quickly contacted families and scheduled intakes quickly after receiving a referral. One respondent explained that this was a welcome change from the status quo with other agencies, where there is often a long delay in returning calls and in scheduling appointments for families.

Providing a cohesive staff and management team

The cohesion of program staff was another strength of the Marigold program mentioned by respondents. Staff members indicated that they worked as a team, communicated well, and supported each other. Furthermore, staff members felt that they received the guidance and support they needed from management. The therapists and case managers were new to Homestead, hired specifically for Marigold, and all have worked together to implement, problem-solve, and continuously improve the program.

Conducting innovative public relations activities

During the first year of program operations, Marigold staff members have undertaken some innovative public relations activities. Several staff members have participated in

radio interviews for local stations in order to raise awareness of the program in the local community. In addition, in May, Marigold held a "Mom and Me" event. This event featured booths with various offerings like beauty makeovers, craft lessons and demonstrations, and information from local service organizations. Businesses were instructed that they were not to sell any products, but could give away samples and prizes. Marigold staff members canvassed local business, many of whom offered door prizes, money, goods, and services in support of the event. In fact, Marigold's out-of-pocket expenses for this event were minimal; local business covered most expenses or provided in-kind contributions. The event was advertised in the local paper, and approximately 60 to 80 families attended. The event fostered name recognition for the Marigold program among local businesses, community members, and families. In Year 2, Marigold staff members are planning to create a speaker's bureau, attend the Umatilla Hispanic Outreach event, and create a postcard advertising Marigold services. Staff members believe that having multiple types of public outreach will create a cumulative effect; people may not remember the Marigold name after hearing about it once, but after hearing about the program in several different contexts families may be ready to reach out to the program.

Program challenges

As described above, the Marigold program has established itself as an important component of youth services in Umatilla County. Like any new program, however, there have been challenges during the first year of implementation. The challenges faced by Marigold included recruitment issues, comfort with FFT, data management, provision of services for a diverse community, and integration of case management into the FFT model.

Recruiting adequate numbers of families

While staff and key stakeholders agreed that the process of making a referral is smooth and that families were receiving much needed services, actually getting enough referrals remained an ongoing concern for the program. The flow of referrals was somewhat less than originally anticipated, although initially the numbers were not a cause of concern for program staff, because the slower pace allowed staff to gradually ease into their roles and responsibilities. However, the original plans for the program called for approximately 100 to 120 girls to be served each year, and the program began services with just 33 girls between February and August 2002. Thus, ensuring an adequate number of referrals during Year 2 will be a priority for the program. The low number of referrals may be attributable to several factors, including resistance within the schools, the small number of girls entering the juvenile justice system, confusion about the type of youth appropriate for Marigold, and the belief among some families that Homestead services are only appropriate for boys involved in the juvenile justice system.

First, Marigold has had difficulty forging relationships with area schools. Several individuals affiliated with area schools made referrals to the program, but on the whole Marigold has not made progress in getting school counselors and teachers to make referrals to the program. Some respondents explained that school counselors were concerned about student confidentiality and, therefore, were unwilling to tell parents about the program.

Counselors did not want parents to know that students came to them with family concerns, and instead, counselors have been tempted to simply pass the families' names on to Marigold. Marigold, on the other hand, wanted parents to be informed of the program and to give consent for the referral to be made. In addition to this issue, Marigold has had trouble in general gaining access to school personnel. Staff members were eager to attend meetings with counselors and teachers, but schools were hesitant to put Marigold on their agendas. Marigold also sent introductory letters and program brochures and fliers that described the program to all counselors at the local middle and high schools and asked that the flier be distributed with newsletters that are sent home to students and parents. Marigold staff questioned several students, and it did not appear that any schools followed through with this request.

Second, while the local County Juvenile Services Division has eagerly referred girls to Marigold, the number of girls getting in trouble with the law and entering the juvenile justice system each year is limited. This referral source indeed provided the program with a steady stream of families, but the numbers simply were not large enough, due to the relatively small population base, for the program to reach, and remain at, capacity.

Third, some girls have not been referred to Marigold because their situations are perceived as too severe. Many respondents indicated that they believed Marigold was most appropriate for at-risk youth who have not yet had trouble with the law, or with girls who have recently begun their juvenile justice involvement. Some respondents felt that girls who were serious offenders or who have spent time in Youth Authority facilities were less appropriate for the program. As one respondent explained, the FFT model encourages families to focus solely on their FFT therapy and to postpone any other needs at that time. However, this respondent felt that some girls have multiple, severe issues that preclude the prioritization of family therapy over other needs, such as drug and alcohol counseling. This reservation about the level of severity appropriate for Marigold may have resulted in the program not getting referrals for some families it would be willing to serve.

Finally, some respondents believed that families may have had misconceptions about Homestead Youth and Family Services that would preclude them from seeking Marigold services. Homestead had traditionally operated programs and residential facilities for juvenile justice-involved boys and had become known for this work in the community. Stakeholders feared that some families may believe that the organization is not appropriate for their family and may even be offended by the suggestion that their daughter is the type of youth served by Homestead.

Gaining comfort with FFT

As discussed in Chapter 3, FFT was a new therapeutic model for all of the Marigold staff members and they have faced some challenges as they have adopted this model. The therapists commented that they have had to concentrate on breaking old habits, such as introducing behavior change efforts early in therapy, and have had to adjust to the fast pace of the FFT model. In addition, at times the therapists would have appreciated additional guidance or resource materials to help them gain comfort with the model. One staff

member wondered whether the first families to enter the program did not receive the same quality of service that later families received because staff members were in a learning phase.[4] All therapists felt that with more time and experience their comfort level will grow. All of them liked the model and felt confident it was a useful model for the families they are serving.

Managing program data

A large majority of the data generated by the program was kept in the CSS, as described in Chapter 3. However, the CSS had programming errors that caused inaccuracies and misrepresentations of the data. While Marigold has been aware of this problem and has requested assistance from FFT, thus far no solution has been found. In addition, some staff members have had technical problems with their computers, which at times made it difficult for them to enter data into the CSS. Furthermore, the program was generating some information that was not included in the CSS. These data were in various forms and were housed in a variety of locations. Some data were kept only in paper files, other data were kept electronically in the CSS, and yet other data were stored electronically in other files. For example, some therapists entered information on contacts between the program and families in the CSS, while others kept this information in paper form only. It is therefore not possible to determine, using CSS data alone, at any given point how many families have been referred to the program, how many have begun counseling, and how many have completed or dropped out of the program.

Providing services for a diverse community

Umatilla County's population is rapidly diversifying. While a large majority of Pendleton residents are Caucasian, the county has a growing Hispanic population and also is home to the Confederated Tribes of the Umatilla Indian Reservation. Homestead had hoped to hire a therapist who spoke Spanish. However, Homestead required therapists to have a master's level education, and no bilingual applicants met this qualification. The program has provided counseling for two Spanish-speaking families by using family friends as interpreters. Some key stakeholders indicated that they were unsure whether the program was equipped to serve Spanish-speaking families and therefore had not referred these families to Marigold. Another stakeholder indicated that she did not refer Native Americans to Marigold because she felt Native Americans could receive services on the reservation. Other stakeholders, however, indicated that they had referred, or would be willing to refer, Hispanic and Native American families to the program.

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[4] Indeed, it is often the case that data from the first year of program operations is considered "pilot" and is not included in outcome evaluations. Marigold may wish to consider this approach when NPC Research launches the outcome evaluation in Year 2.

Integrating case management into FFT

One of the central components of Marigold's services was case management. Chapter 3 discussed the case management services provided as well as the struggle about determining whether, where, and how case management fits into the therapeutic model. The FFT model does not call for case management; in fact, the model states that families should be focused solely on the FFT process and that providing them with case management services may simply address short-term, rather than long-term, needs. Marigold has struggled with balancing the need to satisfy its promise of case management to the Byrne grant administrators with the need to stay true to the FFT model. Initially, before Marigold staff members became aware of FFT's position on case management, the case manager became involved with families early in the therapeutic process. This approach was modified in order to address FFT's concerns, by having the case manager become involved with families later in the process as families enter the generalization phase (Phase 3) of therapy. At that point, the focus of therapy is how to sustain the positive changes families have made and how to deal with any problems that may arise in the future. This phase seemed to be a logical point at which to provide case management services. However, Marigold has decided to continue providing case management services early on to any families who may have needs severe enough to impede the therapeutic process.

Recommendations for Year 2

Based on the experiences and suggestions of staff and key stakeholders and an examination of the activities and data from Marigold's first year of operation, the evaluation team has compiled some recommendations for activities and strategies that address some of the challenges faced during the past year. These recommendations, listed below, include strategies for recruitment, FFT skill-building, data management, and cultural competency.

Recruitment strategies

Ensuring an ongoing, and sufficient, number of families for the program is a primary concern for Marigold staff. Marigold should create short-term and long-term recruitment and public relations plans and budget funds appropriately to carry out these plans. Below are several components Marigold may wish to include in a recruitment plan.

- Clearly identify what severity level of girls the program should serve and educate others on the type of girls appropriate for services. If the program aims to serve all types of girls, including those with the most severe issues and extensive involvement with the juvenile justice system, consider allowing concurrent services while these families participate in FFT.

- When families exit the program, let the referral source know whether the family successfully completed or dropped out. Stakeholders indicated that it they would appreciate this feedback, and this communication would continue to foster positive relations with referral sources. If confidentiality requirements preclude Marigold staff from divulging this information to referral sources, provide clients with a completion letter they can pass along to the referring agencies.

- Create targeted public relations materials for families that can alleviate the fear that Homestead services are only for boys involved in the juvenile justice system.

- Continue to foster opportunities that lead to word-of-mouth and self-referrals. Advertise the program with local religious communities, businesses, and medical professionals who work with adolescents.

- Seek recommendations from other FFT programs for public relations strategies to use with school personnel. Other more established FFT programs may have advice about what worked best for them.

- Consider soliciting advice from other programs that have fostered cooperation from school counselors. For example, Chrysalis, a school-based suicide prevention program in Portland, has trained school counselors on how to approach students and families about program participation. If desired, NPC Research can provide Marigold with contact information for this program.

- Consider approaching the schools from a top-down approach by educating the school board, superintendent staff, and PTAs about the program. Enlist their help and suggestions about how to increase the number of referrals from schools. Be sensitive, however, to concerns about alienating school personnel by focusing solely on a district-wide approach. Balance district-wide activities with school-specific outreach.

- Consider offering schools a service, such as in-service training on how to work with hostile parents. Providing schools with valuable information and assistance may increase school staff willingness to generate referrals for Marigold.

FFT skill-building

Staff members felt comfortable that over time their confidence and proficiency in the FFT model would increase. The therapists were happy with the model and will simply benefit from the experience they will gain serving additional families. The data from the client progress reports does identify three areas in which staff members may wish to focus attention in Year 2.

- Examine the frequency of use of the various FFT interventions in each phase. Why are there a number of interventions that therapists rarely or never use? Examine whether use of these interventions increases as therapists gain confidence in the model. Request additional training on these techniques if therapists are not using them because they do not feel confident with them.

- Examine the therapists' ratings of progress on the goals for each phase. If therapists are reporting little change in progress ratings, determine whether additional training is necessary to help therapists assist families in reaching those goals.

- Provide training and quality assurance with client progress notes entered into the CSS. Without accurate reporting by the therapists it is not possible to accurately capture the program's utilization of the FFT model.

- Examine the characteristics of those families who leave Marigold before completing therapy. Determine whether there are any common characteristics of these families (e.g., demographics, presenting issues) and whether staff members need additional training on these issues to ensure the engagement of these types of families. If necessary, seek advice from more experienced FFT sites about how they have successfully engaged these types of families.

Data management

Marigold staff members created and adapted their data management strategies during the past year. In part as a result of the problems caused by the CSS, the program had several different data management strategies for various types of data. While the evaluation team cannot address the problems inherent in the CSS, the following recommendations will result in cleaner, more complete data for evaluation and program management purposes.

- Consolidate all information on contacts between the program and families in one place, ideally in the CSS. Regardless of where this information is kept, discontinue keeping some information in the CSS and other information in paper form. Numbers of referrals, active cases, completed cases, and dropouts should be up-to-date and kept in one location.

- Enter referral sources into the CSS. There is a field for this information, but it is not currently being entered.

- Administer the JCP risk screen to all families and enter this data electronically. NPC Research has an Access database for the JCP risk screen and would be willing to provide this database, and any necessary training, to Marigold staff. At a minimum, however, this data could be entered into an Excel spreadsheet. The JCP scores will be necessary for the evaluation team to select a similar comparison sample for the Year 2 outcome evaluation.

Cultural competency

Marigold is offering services in a community with a rapidly changing population. The program wants its services to be available for any families who may need them, but must determine how best to serve families from diverse backgrounds. The recommendations below can help guide Marigold's cultural competency efforts.

- Educate referring agencies that Marigold is willing and able to serve families from diverse cultural backgrounds. Some are not aware that Marigold is appropriate for these populations.

- Investigate innovative strategies for securing a Spanish translator, including partnering with other agencies in need of translation services in order to share the cost, or recruiting Spanish-speaking volunteers or intern interpreters.

- Investigate training opportunities for staff members on issues relating to cultural competency and serving Hispanic and Native American populations. Again,

consider partnering with other agencies interested in these trainings in order to share the cost.

Conclusion

In the past 12 months, the Marigold program has evolved from an idea into a fully staffed, operational program providing Functional Family Therapy and case management to Umatilla County at-risk girls and their families. The program has put forth extensive publicity and education efforts and has forged strong relationships with other social service and juvenile justice agencies. Name recognition for the program among service professionals is high, and the program is viewed with respect. Staff members have completed FFT training and have begun providing therapy to families. Preliminary outcome results indicate that families completing therapy show improvements in family functioning and a decrease in risk factors. As the program starts its second year of operation, it will focus on recruiting additional families, and as these families are served it will be possible to further examine outcomes for families, as well as the role that Marigold plays within the Umatilla County social service and juvenile justice community.