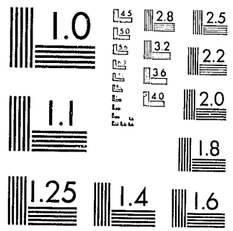


NEP Phase One Assessment: Family Counseling

Summary Report

AMERICAN INSTITUTES FOR RESEARCH
IN THE BEHAVIORAL SCIENCES
P.O. Box 1113, 1791 Arastradero Rd., Palo Alto, Ca. 94302 ● 415/493-3550

AIR-82000-6/81/FR

NEP Phase One Assessment: Family Counseling

Summary Report

Jane G. Schubert

Joan Druckman

Dorothy S. Edwards

Submitted to:
The National Institute of Justice

Grant No. 79-NI-AX-0102

AMERICAN INSTITUTES FOR RESEARCH
IN THE BEHAVIORAL SCIENCES
P.O. Box 1113, 1791 Arastradero Rd., Palo Alto, Ca. 94302 ● 415/493-3550

National Evaluation Program Phase One
Assessment: Family Counseling

ABSTRACT

"You can't return a clean bird to a dirty cage." This statement was made by an adolescent who was, among other things, involved in family counseling. It is in a sense, his version of the rationale for the treatment, and it is compatible with more elegant statements to be found in sociogenic explanations of deviance. The essential hypothesis is that the presence of dysfunctional behaviors on the part of the adolescent signals dysfunctions in a larger unit, often the family. Treatment directed only toward the person who signals the alert is inadequate; all contributors to the dysfunction need assistance. It is this awareness--that the whole family is part of the problem, and therefore must be part of the solution--that led to family counseling as an intervention for reducing the number of entries into the juvenile and criminal justice systems.

In October 1979, the American Institutes for Research received a grant from the National Institute of Justice (LEAA-79-NI-AX-0102) to conduct a Phase I assessment of family counseling activities within the law enforcement/criminal justice systems. Interest in family counseling has been increasing, particularly among individuals charged with providing rehabilitation and/or diversion programs for populations such as status offenders, runaways, nonprosecutorial youth, and adult offenders of certain crimes such as incest. The use of family counseling with such populations stems from a belief that delinquency (emergent or existing) and criminality are strongly linked to dysfunctional family structures. Interest exists also in institutions outside law enforcement; for example, many schools offer counseling programs for youth identified as predelinquent, and some social service workers now look to counseling for ways to help families learn how to function more effectively in areas such as intrafamily communication and problem solving.

The National Evaluation Program (NEP) employs a methodology by which selected areas or domains of interest within the criminal justice system are systematically examined in a variety of settings and conditions. NEP was developed for LEAA in response to a Congressional mandate for LEAA to evaluate its wide range of programs, then share the results with state and local officials. Full-scale evaluation of all LEAA programs is obviously impossible, from cost considerations alone. But even if resources were infinite, full-scale evaluation would be foolish, for many programs are simply not "ready" for evaluation. They could not produce the kinds of information which would provide unequivocal assessments of accomplishment. The NEP therefore adopts what Wholey (1979) has termed the "sequential purchase of information" model. Phase I in this model is designed to learn enough about the activities and outcomes of a particular program area--such as family counseling--to be able to specify

- the current state of the program area,
- the conspicuous gaps in knowledge,

AMERICAN INSTITUTES FOR RESEARCH
PO Box 1113 Palo Alto, CA 94302

- the likelihood of these gaps being filled by additional evaluative efforts, and

- the nature and scope of sensible next steps, if any can be recommended.

If further study was recommended, the culminating activity of the first phase would be to design and test the feasibility of the proposed approach.

The NEP Phase I assessment of family counseling consisted of several tasks. The first was to specify the topic area by defining the family counseling domain within the criminal justice system. We developed five criteria which were confirmed in telephone conversation with several practitioners. The next task was to identify projects within the domain, a procedure that involved several steps, beginning with a canvass of 2,071 agencies in the criminal justice system and the mental health field that lead to a further refinement of our inclusion and exclusion criteria. The final step was the selection of 470 agencies that represented family counseling activities provided for criminal justice client-families. Staff members then visited 18 of these agencies for about three or four person-days. We interviewed individuals inside and outside the agency who were knowledgeable about the program. The remaining agencies (452) received a 50-item questionnaire designed to enrich our descriptive data on key project dimensions.

One other task characterized our approach, the development of rationales based on an examination of the literature and written documentation of specific programs. A rationale formally represents the network of assumptions that underlie a group of family counseling projects. They may be viewed as a network of hypotheses that make explicit the dynamics of the cause-effect relationship. The usefulness of this method is its value in determining which outcomes can be attributed to inputs. Initially, we constructed seven prototypic rationales that served as templates of family counseling activities. These were reviewed by the on-site practitioners and program directors to determine the similarities shared between the prototypic rationales and the programs-in-place. Based on these comments and the findings derived from the site visits, we developed three general rationales that reflect a continuum of family intervention, from least to most:

Model I. The Comprehensive Services Approach. This model offers multiple services to multi-problem families, where family counseling may not be a primary focus. The clients tend to be low-income, often single-parent families, with insufficient or inappropriate coping skills. Their needs are as basic as food, shelter, medical care, and legal assistance. Agencies in this model tend to have resources within the agency to help the family with survival needs in addition to dealing with psychological problems among family members. A client-family will often receive agency services over a long period of time. If Maslow's hierarchy has any merit, it is most clearly demonstrated in this model, where a family struggling to survive is unlikely to be receptive to therapy. The agencies in this model recognize and react to this problem.

Model II. The Family Management Approach. Another tentative model seemed to focus on skill acquisition and development--parent effectiveness training, communication skills, conflict resolution, and problem solving skills. "Homework" assignments and contracts were common. For example, at one site visited, the parents of a boy who "can't do anything right" were sent home with the assignment that they must praise him twice before they were "allowed" to criticize him once. Crisis intervention and problem management also seemed to be important aspects of this model.

Model III. The Family Restructuring Approach. A third model included sites where family intervention was the sole or primary approach, designed to bring about change in the family system. The therapist develops a "diagnosis" of family functioning, a set of short and long-term treatment goals, and may escalate stress to alter deeply ingrained dysfunctional family patterns.

From an evaluation perspective, these rationales are a necessary first step toward assessment by providing a basis for argument on evaluation issues and the required measures, an examination of a set of treatment strategies across projects, a method for identifying success criteria at each step in the sequence of events, and a way to pinpoint a particular component of an intervention that may require modification.

The conclusions are presented as (1) overall impressions of the family counseling domain and (2) gaps in knowledge--conditions or outcomes that need some investigation so that the potential of family counseling may be better understood. Two examples of each are:

Impressions.

1. "Family" is a loosely applied term.

Practitioners who deliver family intervention services may work with several configurations, that can include an identified patient, single parent, two parents (natural or mixed), siblings, significant others (often a close friend of a single parent), and extended family members. Meetings may involve the counselor and one or more family members: participants at each session may vary. It isn't clear what "family counseling" means. Some counselors argue that if the entire family (household) does not meet together for a minimum number of sessions, real family intervention cannot occur. Others disagree, and treat unit(s) other than the entire family (usually referred to as subsystems) but label this as a family intervention. We found little consensus in the application, but general agreement that "family systems" were being treated.

2. Family counseling has won a great deal of community support.

There are simply a lot of believers outside the family counseling agencies who credit them with a variety of successes--in reducing recidivism, lightening the load of the intake worker at Juvenile Court, and providing an option to police officers who pick up a youth on the streets and now have a place (other than court) to take this person. Whether or not evidence supports this notion, the idea is

very strong. The basic idea (of the family as an important element in juvenile deviance) is appealing and the practitioners have been persuasive. The police, the courts, and the schools are generally supportive.

Knowledge Gaps.

3. What are the indicators of readiness to receive counseling? How can dropouts/failures be identified?

Terminations occur prematurely for several reasons--e.g., people stop coming to the meetings, they don't want to admit that a family problem exists. But apparently little is known about who stops coming and why--are these the people most in need? Agency resources are typically limited, allowing little or no time to pursue the dropouts. Many counselors prefer to work with the people who want help, rather than drain one's energies on those who reject. In a real-world context, there is a certain logic to that argument. What are the advantages/disadvantages of focusing on families which (a) are most in need, (b) are most receptive, or (c) are most promising? Knowing more about the leavers may contribute to the success.

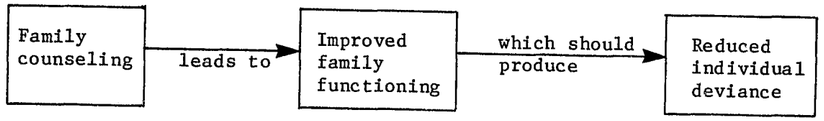
Counselors report that much of their energy is devoted to "engaging the clients." To some extent, perhaps counselors are getting people in a family ready for counseling as a family.

4. What benefits, if any, accrue to the siblings?

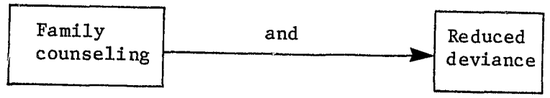
We raise two issues about the siblings of the identified patient-the first is the extent to which improved family functioning prevents them from committing minor offenses, or other troublesome behaviors. What happens within the family--their relationship to parent(s) and each other? The second is their personal role in the counseling, particularly among very young members. On some occasions, we heard reports about two-year-olds whose distracting behavior during sessions stimulated discussions about ways in which families cope with demands placed by one member on other members. From a different viewpoint, is it constructive to encourage the attendance of children who may or may not be aware of the dissonance in a household to witness the conflict and problem escalation often occuring in a family counseling meeting?

The evaluability of family counseling is addressed by suggesting ways in which the conceptual rationales enhance both program development and evaluation, summarizing existing evidence of treatment effects, and considering how a family counseling program might be evaluated.

For many of the programs examined, recidivism was the most common outcome used to measure success. The direct success of family counseling in improving family functioning is largely ignored. The basic rationale is that



but the common measurement practice within the criminal justice system is



without the intervening measurements. We suggest some requirements for conducting an evaluation, such as an explicit definition of the intended treatment. This is critical and should hold for clients in a given project. Other requirements refer to individual clients and should be organized on a case basis, for example, the basis for assignment to family counseling, historical and demographic descriptors, and estimated appropriateness of assignment. Additional requirements such as time and place of meeting, attendances, targets for next meeting, status at termination or counselor's prognosis, can be organized in advance as a checklist.

If data were maintained in an organized way by a number of projects, aggregation across similar projects could occur, and questions such as "what is the effect of whole-family versus part-family participation?" could be answered. We could then turn to family counseling within the criminal justice system and examine measures of recidivism, offenses by other family members, and others. Longerterm criteria of success (e.g., marital stability, improved family functioning) may then be considered.

For further information about this study, please contact Dr. Jane G. Schubert, American Institutes for Research, Box 1113, Palo Alto, CA 94302.

Table of Contents

Tables and Figures

All happy families resemble one another,

but each unhappy family is unhappy in its own way.

—Tolstoy

Introduction

This report marks the end of an 18 month Phase One assessment of family counseling activities within the law enforcement/criminal justice system. The study was conducted by the American Institutes for Research (AIR) under a grant from the National Institute of Justice (LEAA-79-NI-AX-0102).

The National Evaluation Program (NEP) is a response to the evaluation mandate of the 1973 Crime Control Act. The legislation directed the National Institute to evaluate LEAA projects, then share the findings with state and local planners. To conduct full-scale evaluations of a large volume of projects presented a challenge which is addressed by the NEP approach. This approach consists of a systematic collection of information about a specific topic area to determine what is currently known about that area, and what might be desirable to know. Family counseling is one example. Phase One focuses on this collection effort by relying on existing documentation and on-site project observation. The decision to continue with a Phase Two depends on the findings of Phase One plus other considerations of cost, utility, and availability of funds as determined by the sponsoring agency.

Phase One assessments employ a common methodology designed to comprehensively describe the current state of the program area and what, if any, useful additional information could be obtained by a more intensive evaluation. Phase One can be characterized as a preliminary assessment.

This summary report was preceded by other products during the course of the research:

Druckman, J. Family counseling in the criminal and juvenile justice system: A literature review and annotated bibliography. Palo Alto, Ca.: American Institutes for Research, 1980.

Schubert, J., et. al. NEP Phase One assessment: Family counseling. Site reports. Palo Alto, Ca.: American Institutes for Research, 1980.

NEP Phase One assessment: Family counseling. Directory of mail survey participants. Palo Alto, Ca.: American Institutes for Research, 1981.

As with any project this size, the products reflect the contributions of many individuals. I am grateful to each of them. In September, we invited a group of individuals knowledgeable about the family counseling domain, juvenile justice, and program evaluation to meet with us for a mid-project discussion of our activities and to review our family counseling rationales. Those present were:

Dr. Roger Baron
Consultant
Family Therapist/Attorney at Law
Woodacre, California

Dr. Malcolm W. Klein
Senior Research Associate
Social Science Research Institute
Chair/Sociology Department
University of Southern California
Los Angeles, California

Dr. Johanna M. Mayer
Consultant
Family Therapist/
Clinical Psychologist
Menlo Park, California

Mr. William C. Stephens
Consultant
Diversion/Juvenile Corrections
Oklahoma City, Oklahoma

I am very appreciative of the time given to us by the practitioners and other staff members at the agencies we visited and to those who completed the mail survey questionnaire. Several AIR staff members participated in this study: Dr. Joan Druckman, Ms. Marian Eaton, Dr. Dorothy Edwards, Ms. Jude Flagle, Dr. Robert Krug, Ms. Fran Stancavage, and Ms. Winnie Young. I thank them all.

This summary report was written by Dr. Druckman, Dr. Edwards, and me. Dr. Krug reviewed the draft and wrote the Section C in Chapter VI on evaluating the domain. The opinions expressed are those of the authors. They do not represent the opinions of the National Institute of Justice or other contributors to this project.

Jane G. Schubert
Principal Investigator

I. Perspective

A. A Family-Oriented Treatment Approach*

Family counseling is a common label shared by a myriad of programmatic approaches designed to treat a wide variety of problems. In its current forms, family counseling reflects a growing trend, begun in the 1950s, toward viewing individual disturbances as sociogenic in origin. The essential hypothesis of the sociogenic view is that deviant behavior on the part of the individual derives from dysfunction in larger social units such as the family, neighborhood, or even society in general. Rather obviously, the family can be considered as a treatment unit while larger aggregates cannot. Hence the growth of family-oriented treatment and the absence of "neighborhood therapy." Treatment directed only toward the person whose behavior signals the alert is inadequate; all contributors to the dysfunction need assistance. Virginia Satir, a pioneer in focusing attention on the need to treat the whole family explains:

> The family is a life factory where nothing happens by itself. There could be no family without the participation of all involved. Everyone responds to everyone else--although much of what goes on is beneath our level of awareness. (Satir, 1981)

Satir further characterizes family life as the tip of an iceberg because most people are aware of only a small fraction of what really happens. A fundamental goal of treatment is to help the family become more aware of the hidden aspects of its functioning and to learn how to manage them more effectively.

As the idea of treating the family developed among theoreticians and practitioners, a variety of approaches emerged. One example of an intervention strategy is a psychodynamic model, associated with Ackerman (1958), Boszormenyi-Nagy and Framo (1965), and Whitaker (1976), in which an examination of the past is the vehicle for resolving underlying conflicts. The presenting problem symbolizes these conflicts. A second approach uses a quite different strategy by addressing the situation that brought the family to treatment. The problem receives the attention: communication patterns (verbal and nonverbal) among family members are observed, feelings of self-worth are examined in order to improve upon the way a family functions. Proponents of this interactional-communications model include Jackson (1968), Haley (1973), and Satir (1964). Another pragmatic and

---

* We follow the lead established by many practitioners of using family therapy and family counseling interchangeably. Our data indicate that many family counselors apply the concepts proposed by the leaders of family therapy. Our primary concern in this study is to describe the types of family-oriented treatment received by criminal justice clients.

present-focused strategy appears as a structural approach in the work of Minuchin (1974). He attacks the boundaries and conditions within a family by disrupting the existing balance in an effort to restructure the family. The transgenerational model (Bowen 1961) agrees with the structuralists that family boundaries are integral to family functioning, but Bowen delves into boundaries across generations to explore interaction patterns that may upset the family system. Transgenerationalists believe that the family system balances the relationship between a need for individuality and a need for family togetherness. A final example of treatment exists in the present centered behavioral model (Stuart 1971; Parsons and Alexander 1973), which views a presenting problem as an acquired behavior(s) which can be changed. A variety of strategies, such as contracts and token economies, are applied to bring about desirable new behaviors. A major feature of this approach is the emphasis on external changes as compared with the more affective nature of the communications strategists.

Conversations with field practitioners reveal a host of applications of the overall theories summarized in the preceding paragraph. These practitioners represent various disciplines--psychiatry, psychology, social work, mental health, and counseling/guidance--and their selected treatment interventions often reflect a blend of their formal education and specialized training and experience in family-oriented treatment. While acknowledging the diversity of the domain, we attempt to convey the "flavor" of family counseling by highlighting the events which often occur when a client-family receives treatment.*

1. The Alert. One family member usually alerts the need for assistance. The signal is often an event such as a youth who runs away, vandalizes property, or experiences school-related problems. More private alerts may be cases of drug, child, or spouse abuse. But eventually, the problem attracts the attention that leads to whole-family treatment.

2. The Participants. The entire family typically should be included in the treatment--the identified patient, parents, spouse or significant other, and/or persons who play critical roles in the family constellation. If the family is part of the problem, it must be part of the solution. There is, however, considerable flexibility in adhering to this principle.

3. The Sessions. Meetings usually last approximately 45-90 minutes; the frequency of occurrence depends on several factors and is guided by the practitioner. Some treatment approaches require more intensive and long-term sessions that necessitate weekend marathons or short-term residential stays.

4. Period of Treatment. Wide variation exists and is usually keyed to funding parameters, agency rules, seriousness of the presenting problem, or to differing philosophies of treatment. Short-term treatment may be 3-5 sessions which last from 1-3 months. Even though a client-family terminates treatment, it may remain on the agency records for some time to permit follow-up or opportunities for help with a new situation. When several direct services are given to a client-family or if the family needs intensive therapy, the treatment period occurs over a longer time period.

* These events reflect data gathered from on-site interviews of project managers and counselors.

5. The Treatment. A practitioner may choose to focus on immediate relief of the presenting problem, family interaction patterns, family genealogy, family rules, parent-child conflict, marriage counseling--all, some, or none of the above. During the treatment process, the participants may set goals and conduct intermediate assessments of success in reaching the goals. The range of strategies is enormous.

6. The Termination. This event normally occurs by mutual consent between the practitioner and the client-family and is a goal toward which both parties strive. Voluntary withdrawal by recipients of a treatment, may also happen, in which case the intervention ends prematurely.

B. The Criminal Justice Interest

Attempts to establish a causal link between the family and criminal behavior are not new. For several decades, researchers examined the influence of family structure, maternal employment, family dissension, communication, interactive patterns, and other family variables to learn more about the dysfunctions of individual members and their relationship to unlawful behavior. There is little agreement about the specific findings, but apparently some overall agreement that a relationship does exist, i.e., that some unlawful behavior may be associated with dysfunctional family dynamics.

The acceptance of this basic tenet, coupled with a growing recognition that disorders manifested in criminal behaviors must be controlled, led criminal justice practitioners and decision-makers to consider the potential of family counseling as a treatment approach. For the family of the adult offender, crises often arise at the time of arrest or conviction (Weintraub, 1976) or when the offender reenters the family following institutionalization. Family treatment aims to ease the painful adjustment that frequently accompanies such events. In a different context, family therapy is sometimes the selected treatment mode for sexual abuse of one family member by another.

But family counseling draws its most ardent supporters from those charged with diversion and deinstitutionalization of troubled youth.* For

* We note here the point of view offered by Lemert, that the establishment of programs aimed toward special outcomes by juvenile justice officials violates a fundamental principle of diversion--redirecting cases which otherwise would be processed through the system. The support of youth-serving programs either in-house or though referral, permits the juvenile justice system to influence young people who probably would have been released after minimal involvement with the system (Lemert, 1981). The implications of this perspective receive more attention in Chapter IV, Section C, clients.

these officials, the appeal is pragmatic, as they select the strategies and interventions offered by the theorists that address the immediacy of the world in which they must operate. The features of family-centered treatment law enforcers find most attractive are:

1. Attention to the Immediate Problem. An event occurs which precipitates action by several people--a law enforcement official, a parent, a service provider. The action focuses on relieving the tensions created by the event before proceeding to underlying causes.

2. Definition of Purpose. In most cases, treatment aims to restore normalcy within the family or help the family recognize and cope with potentially explosive events.

3. Length of Treatment. Most interventions are short term: focus on the present directs attention to the problem at hand. Time increases on an as-needed basis, frequently with a new service provider.

4. Environmental Support. Several minor juvenile offenses (incorrigibility, running away from home) are closely linked to family matters. Family-oriented treatment appears relevant. Recent legislation (JJDP 1974 and DISO 1977) endorses the development of youth-serving agencies as a means of diverting minor juvenile offenders from the criminal justice procedures. Such agencies, usually comunity-based, received funding to offer appropriate services.

5. The Spread of Effect. It is often true that an offender who appears in court may not be the first family member to encounter the system. Learning about the behaviors that foster family involvement in deviance and designing a treatment to extinguish such actions is potentially very powerful.

The appeal led to actions either within or supported by the criminal justice community in the form of programs associated with probation departments, police departments, juvenile courts, youth centers, family counseling, and guidance centers. The activity varies in both the extent of family-oriented treatment by departments and agencies and the sophistication of their programs. Examples of family-oriented treatment programs include:

1. The Sacramento County 601 Diversion Program, located within the probation department. This was the first of its type, and is probably one of the most popular approaches which has been imitated nationwide. Designed for use with status offenders, family treatment is short term (fewer than five sessions) and intensive. In 1972, services expanded to those accused of minor criminal offenses (602s). The project receives local support, following initial funding by the California Council on Criminal Justice, County of Sacramento, and the Center on the Administration of Criminal Justice.

2. El Nido Services in Los Angeles is a community organization which specializes in family counseling through 14 offices, 3 residential lodges, and in 24 schools. It services juvenile diversion clients through support

from Project HEAVY, a private non-profit corporation created to help youths in trouble. These clients are referred by police and court personnel, and may receive up to 10 counseling sessions.

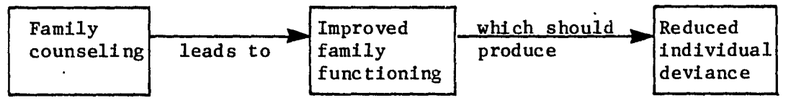
3. The Family Intervention Service in Media, Pennsylvania resides in the Juvenile Court Building, providing probation offices an easy access. Although initially funded by a three-year LEAA grant, the program currently receives fiscal support from the county. The probation department refers most clients, whose offenses include theft, burglary, and delinquent acts.

4. Youth Services for Oklahoma County is a private, non-profit agency serving delinquent youth through its skills education program, a runaway youth program, and a crisis management counseling program. Families in need are identified by the Juvenile Bureau, the police department, and other educational and community agencies.

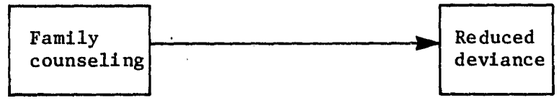
5. Brockton Comprehensive Counseling Program, Massachusetts, provides a range of diversion services to delinquent youths and their families: family counseling and an alternative school comprise the featured activities. Funds and referrals come from the Massachusetts Department of Youth Services, which handles court-referred status offender and delinquent cases. Families seen by the staff typically require assistance for a variety of problems.

6. The Western Ohio Youth Center is a residential treatment facility for 12-18 year old non-assaultive male juvenile offenders. All center activities are used as opportunities to promote appropriate behavior: individual treatment plans include individual, group, and family therapy. The Center receives its primary support from reimbursement and subsidy monies.

Has the family-oriented treatment approach made a difference? For the programs we studied, recidivism was the most common outcome used to measure success. The direct success of family counseling in improving family functioning is largely ignored. The basic rationale is that



but the common measurement practice within the criminal justice system is



without the intervening measurements. The intervention strategies selected by a family counselor who works within the criminal justice system are doubtless influenced by the goals of the system. In some cases, the range of options may narrow because the system governs what family counseling services are offered, particularly when the number of meetings between the counselors and families is restricted (e.g. due to funding restrictions, backlog of cases, etc.).

For example, a youth who has been picked up by the police because of prolonged absence from school may be taken to a counselor for help. If the goal of the system is to return the youth to school, the counselor will focus attention on a set of behaviors which may not have received the same priority if the counselor met with the youth as a private practitioner and chose to focus on other goals. The selection of goals also influences the judgment of success; family counselors and law enforcement officials often disagree on this issue.

One mandate of this study was to examine measures used by the criminal justice system. Examples of some measures used in evaluations of family counseling projects are summarized below.* We address this more thoroughly in Chapter VI, Sectin B, noting evidence commonly used to determine outcomes; and design features of specific studies.

Baron and Feeney (1976) use recidivism rates as an indicator of the effect of the Sacramento 601 Diversion Project. Both project and control clients treated during the first year of the project were tracked for a 12-month period that began from the initial treatment. They report findings, at the conclusion of 12 months, of a lower recidivism rate for project (46.3 percent) than control (54.2 percent) clients for a 601 offense or for a violation of the penal code. In a study of 190 pairs of adjudicated delinquents from the Delaware County, Pennsylvania, Juvenile Court (one group received probation services; the other family therapy services), results showed a reduction in the number of offenses for both groups immediately following treatment. However, during the second year following treatment, the probation services group showed a statistically significant increase in offenses, while the therapy group maintained the same low level observed at the end of one year (Johnson, 1977). Sutton (1978) reports on a comparison of recidivism rates for CHIP (children in need of supervision intervention project) clients with rates for other CHINS (children in need of supervision) offenders in a county in New Mexico. The CHIP clients were predominantly high risk which is believed to contribute to a slightly higher recidivism rate than the low-risk cases. Even so, 67 percent of the CHIP clients in the sample avoided subsequent contact with juvenile authorities. In Fairfax County, Virginia, the County Office of Research and Statistics (1977) examined family counseling operations during a six-month period (to parents of delinquent children). The findings indicate that family counseling contributed to a decrease in recidivism of 90 percent.

* These are illustrative. Inclusion in this report does not represent endorsement of the methods or findings cited.

While acknowledging the importance of recidivism, many law enforcement officials use other gauges to attribute success to family counseling programs within their jurisdictions. These indicators convey a belief about the impact of such programs and therefore deserve attention. The following examples illustrate some viewpoints of criminal justice representatives.* The use of family counseling:

1. offers a new perspective in assessing service delivery needs which avoids a punitive orientation and focuses instead on need. Tolerance among many law enforcement officials increases as they accept an individual's misbehavior as a family dysfunction;

2. helps to prevent a premature labeling of a youth in trouble;

3. offers an alternative to traditional methods of handling troubled youth;

4. has potential as a preventive technique for siblings of the juvenile offender;

5. provides relief to a patrol officer who picks up a youth and now has some place to take the individual instead of the court;

6. permits court intake officials to concentrate on more serious offenders by reducing their time devoted to minor offenders.

Widespread proliferation of family-oriented treatment programs in the criminal justice system occurred within the last 5-8 years. It was time for a systematic examination of these programs, and a Phase I assessment under the National Evaluation Program (NEP) was commissioned.

C. NEP Phase I Assessment

The format summarized below guided the preliminary assessment of family counseling activities which serve some offender populations who come in contact with law enforcement agencies.

The NEP employs a methodology by which selected areas or domains of interest within the criminal justice system are systematically examined in a variety of settings and conditions. NEP was developed for LEAA in response to a Congressional mandate for LEAA to evaluate its wide range of programs, then share the results with state and local officials. Full-scale evaluation of all LEAA programs is obviously impossible, from cost considerations alone. But even if resources were infinite, full-scale evaluation would be foolish, for many programs are simply not "ready" for evaluation. They could not produce the kinds of information which would provide unequivocal assessments of accomplishment. The NEP therefore

* These illustrations were generated from on-site interviews conducted during this study with judges, probation officers, and police officers.

adopts what Wholey (1979) has termed the "sequential purchase of information" model. Phase I in this model is designed to learn enough about the activities and outcomes of a particular program area--such as family counseling--to be able to specify

1. the current state of the program area,

2. the conspicuous gaps in knowledge,

3. the likelihood of these gaps being filled by additional evaluative efforts, and

4. the nature and scope of sensible next steps, if any can be recommended.

The NEP Phase I Assessment of family counseling programs, conducted by AIR is described in the remainder of this report.

II. Procedures

A. Specifying the Topic Area

Typically, a National Evaluation Program begins with an assessment of what is currently known about a topic of interest to state planning agencies and other decision-makers in the criminal justice network. The conceptual nature of these topics of interest appears in the title--a street lighting project, a police training project, an employee theft project, or a citizen crime reporting project. The case of family counseling represents a departure from the past; the topic is broader in scope and while programs share a common label, they are less delimited by it.

If we followed the model developed for earlier NEP assessments, the first step would be to catalog all family counseling projects nationwide. We questioned the usefulness of such a step, anticipating a collection of a huge volume of projects characterized by an equally broad range of activities. It would be necessary to select among them for our investigation. We decided to delimit prior to our collection of programs, by establishing some boundaries for the domain of interest. Such boundaries assist in striving for sufficient homogeneity among the projects to serve as a basis for developing a generalizable model or models, applicable to a domain. Failure to do so would lead to an examination of "one of everything."

1. Defining Domain Boundaries. The first cut in defining the family counseling domain reflects the inputs from telephone conversations with approximately 10 practitioners and a review of the research and theoretical literature. Special attention was given to family counseling within the juvenile and criminal justice system. Five criteria were developed.*

   a. The project must connect to the criminal justice system. This criterion is part of our mandate. We excluded civil cases from our investigation because they went beyond the scope of our effort.

   b. The treatment must purport to be whole family oriented. The conceptual underpinning of family counseling is a family systems approach. Family may apply to all residents of a household, regardless of the legal and common law relationships.

---

* We relaxed two of these criteria (b and c) after the site visits began. Counselors differ in their definitions of what a "family" means, with respect to treatment: we elaborate on this finding in Chapter IV, Section D. Whether or not the causes which precipitated an event are dealt with in the sessions remains a matter of approach, and sometimes parameters imposed by the context of the intervention. We tended to apply the "on-the-spot" element of the criterion more successfully.

c. The counseling must address the causes leading to the disruptive event, as well as settle the disruption. This criterion excludes "on-the-spot" management of crises. There must be scheduled interventions following the event.

d. There must be more than one counseling session.

e. The primary treatment is family counseling. We preferred projects where family counseling was not a support or adjunctive activity within the context of treatment for something else, such as drugs or alcohol.

2. Identifying Projects Within the Domain. The first step of this task was to contact a wide range of sources that could contribute to a pool of agencies and projects from which we could derive a sample for this study. Our list of contacts included: LEAA/NCJIS lists of block grants and discretionary fund projects; lists of State Planning Agency directors; court administrators; heads of State departments of Correction; police chiefs; and community mental health centers. Our goal was to adequately canvass both the criminal justice and the mental health fields. We selected community mental health centers so as not to miss any special family counseling projects that service criminal justice clients. The net was cast as broadly as possible so as not to exclude any type of agency which offered family counseling to criminal justice clients. We anticipated overlap among the sources: the major concern was coverage.

The mailing list contained 2,071 agencies and individuals to whom we sent a cover letter that outlined our study and included a stamped, self-addressed return card on which the recipient was asked to identify family counseling project(s) that: (a) are linked to the criminal justice system; (b) are whole-family oriented; and (c) engage their clients for more than one session. The 511 respondents identified 964 candidate projects for the sample. We interpret the returns as indicative of knowledge about family counseling activity: many projects were listed more than once.

The next step in selecting a sample was to learn more about the types of projects that constituted the candidate pool. We began by conducting semi-structured telephone interviews with 99 projects, selected to represent all the identified types (e.g., Youth Service Bureaus, juvenile court intake units, probation departments) and geographical regions. The questions asked aimed toward learning about project operations with respect to the five boundaries. The findings guided the construction of inclusion and exclusion criteria for further refinement of the sample. Projects were included as candidates for the sample under the following conditions:

a. Special programs for juvenile or adult offenders under the auspices of a family service or community mental health agency.

b. A program or program component of a youth service bureau. Our phone calls indicated these programs generally offer family counseling to juvenile offenders.

c. Status offender diversion program. These programs may be found in a number of different settings such as probation departments, social service agencies, and youth service agencies.

d. Short- or long-term residential treatment centers where family counseling is a major component.

e. Shelter or "home" facilities, because these places often provide family counseling in an effort to return the juvenile to his/her home.

f. Juvenile court services, because they often have some kind of family counseling programs.

g. Many programs with "unusual" names that do not reveal the nature of the service. These programs were tentatively accepted and further explored by calling agencies to find out what they did. (Examples: Xanthos, Friendship Place, TAS, Omega)

Programs were excluded as candidates for the sample under the following conditions:

a. They are components of administrative departments which generally do not provide direct services (e.g., State Department of Corrections, State Planning Agency).

b. Work focuses on adults or children who are mentally retarded, emotionally disturbed, or learning disabled.

c. Adult diversion programs which do not include family counseling in any significant way as part of the treatment.

d. Family service associations which service only a small minority of cases from the criminal or juvenile justice system. If a special program under the auspices of a family service agency is indicated, then it should be accepted. Also, if it is the only counseling facility in the area it should be accepted.

e. Comprehensive community mental health centers, because only a small minority of cases were referred from the criminal or juvenile justice system. NOTE: if a special program under the auspices of the CMHC is indicated, then it should be accepted. Also, if it is the only counseling facility in the area it should be accepted.

f. Predelinquent school or community prevention programs, because they do not have a "delinquent" population. The treatment is more educational than counseling and typically does not involve the whole family.

g. Psychological services and psychological testing services, because they generally do not provide counseling. Their main focus is diagnosis and evaluation with subsequent recommendations for treatment.

h. Domestic relations and family conciliation court services, because they do not deal with the appropriate target population. These services typically work with cases involving divorce, remarriage, or adoption and not with families of juvenile or adult offenders.

i. Juvenile intake services, because these departments typically do not provide direct services. Their general function is to diagnose, evaluate, and refer.

j. Police crisis intervention services generally do not provide more than one session with the family.

With this set of inclusion-exclusion criteria, project staff independently judged the remaining 865 projects regarding appropriateness for inclusion in the sample. Interjudge agreement was 93 percent. We then jointly reviewed each case about which the judges disagreed and decided on its status. This procedure resulted in 470 projects: every state except Mississippi was represented.

B. Developing Project and Theoretical Rationales

Early in the project, we began to examine published literature in family counseling and family therapy domains, and written documentation from specific programs. Based on this information we developed two kinds of rationales: those based on (1) theoretical approaches to family counseling and (2) particular "types" of agencies or settings that provide family counseling. We developed three theoretical rationales: (1) structural, (2) behavioral, and (3) interactional-communications; and four "project" rationales: (1) Youth Service Bureaus, (2) Sacramento Diversion Program, (3) Iowa Family Therapy Teams, and (4) Community Mental Health Centers. The rationales were developed in part to serve as prototype rationales for use during site visits. Similarities and differences between the prototypes and site activities influenced later development of the basic conceptual models.

C. Visiting Sites

We actually conducted three kinds of site visits: (1) preliminary visits, (2) pilot site visits, and (3) comprehensive site visits. The preliminary visits to two agencies increased our knowledge and awareness of family counseling activities in the criminal and juvenile justice system; these visits to local agencies were brief (one-half - one day) and we spoke only to agency personnel. We used our knowledge to help us develop a draft of the site visit interview protocols.

Two pilot site visits helped us assess the usefulness and effectiveness of our forms and procedures The final forms consisted of predominantly open-ended items in these areas: project perspectives, project characteristics, service delivery, intake and assessment, and project outcomes. We developed a separate counselor interview form to collect case-specific data.

After a series of phone calls to prospective sites and a review of documents received from many projects, we selected 18 sites to visit, using the following criteria: (1) regional distribution, (2) type of agency setting, (3) extent and type of available documentation, (4) type of therapeutic approach, (5) length of intervention, (6) type of staff training and expertise, (7) funding source, (8) innovativeness of service, and (9) client population. In general, we wanted to obtain a sample of agencies that represented a wide range of characteristics and family counseling activities. The purpose of a site visit was to observe first-hand what a family counseling environment is like and to collect data in more detail than possible from a mail survey questionnaire.

The site visits generally lasted about three or four person-days. During the visits we interviewed several key program persons such as the program director, the clinical coordinator, one or two counselors and the intake worker, as well as persons external to the agency/program such as referral sources, advisory board member(s), judges, police, and teachers. Site agendas required data collection on:

1. the history of the program and influences that shaped its current activities;

2. details concerning the goals and objectives of the program and the rationale for each;

3. the actual project environment--how it was managed, with what resources, and with what real and expected outcomes;

4. the external factors that influenced the projects--referral sources, local governments, juvenile courts, etc.;

5. project documentation with a special emphasis on existing or potential measures of process and outcome variables; and

6. available evaluation findings.

In addition to interviews, project staff often directly observed counseling sessions (either in the same room or behind a one-way mirror) or reviewed videotapes of previous sessions. We also toured the facilities.

At the completion of each visit, the visiting staff summarized the data collected in a report; the reports average about 20 pages in length. These individual reports comprise a single volume which was distributed to all participating sites. The reports simply describe what we learned: we did not evaluate site operations. A profile of the sites visited appears at the end of this chapter.

D. Conducting the Mail Survey

We conducted a mail survey, designed to enrich our descriptive data on key project dimensions such as agency characteristics, project documentation, research and evaluation activities, staff characteristics, client characteristics, and direct services. The questionnaire contains about 50

items that represent approximately 175 variables. This instrument received careful scrutiny from two AIR senior staff members and seven family counselor practitioners.

The mail survey sample included 452 agencies: each received a cover letter explaining the project plus a self-addressed return envelope. The responses totaled 299 (66 percent), including those who returned questionnaires after the first mailing and those who returned the forms after a followup postcard with a second request for a completed questionnaire. In the following paragraphs, we summarize why 105 questionnaires were removed from the 299 that were received and our knowledge about the 153 agencies which never responded.

1. Removal of 105 questionnaires. Table II-1 shows why some agencies were dropped.

Table II-1 Reasons for Dropping Questionnaires*

Reason	N
Not a direct service provider	10
Family counseling secondary service	42
Not enough clients	1
Clients not from criminal or juvenile justice system	6
Agency/program no longer in operation	4
Agency/program just started	1
Alcoholism/drug treatment	1
Divorce counseling	3
Foster parenting	1
Refusal to participate	23
Incompleted questionnaire	1
Questionnaire sent back too late	1
Duplicate questionnaire	3
Returned from post office	5
	112

(* 7 agencies gave two reason for non-participation)

The primary reason cited is the low level of family counseling activity within a project or agency. Determination of the level was made by the respondent (who indicated that family counseling played a very minor or secondary role in their program and served few clients) or by AIR project staff. AIR screened each questionnaire, using an item on the first page that asked "does your agency provide family counseling to criminal justice clients" and, if so, "approximately what proportion of the overall number of clients served does this represent?" If the proportion was 15 percent or less, then the questionnaire was dropped, on the grounds that the activity was not a primary service of the agency.

Briefly, additional justification for removal of a questionnaire included a refusal to participate (no time to fill out forms, too lengthy a form, or absence of data), the indirect role of an agency as a family counseling service provider (usually referral or information purveyors and single case assessment leading to subsequent referral), focus on problems outside the scope of our study (divorce, foster parenting, alcoholism, substance abuse). Some agencies were decreasing activities because of anticipated loss of funding; others serviced clients outside the criminal justice system. We had the unusable responses due to incompleteness, duplications, late returns, or post office returns.

2. Nonrespondents. The nonrespondents total 153. We contacted 20 agencies by telephone to learn why they did not return the questionnaire. The types of agencies and the number phoned appear in Table II-2.

Table II-2 Profile of Nonrespondents

Agencies	Number	Number Contacted
YSB/Youth service centers	30	6
Counseling centers, CMHCs, Youth & Family Services	49	7
Group homes, residential treatment, detention	9	no calls returned
Law enforcement agencies	24	3
Shelter care/runaway programs	13	1
Youth oriented/diversion projects	23	3
Miscellaneous, unidentifiable	4	
State family services agency	1	
	153	20

Explanations for agency actions are listed below.

9 Addressee left the agency. The staff was in transition at the time so that new director was unable to answer, or the office changed addresses and thus did not receive the form.

5 No recollection of the survey and no other comments made.

4 Addressee or staff did not have the time or resources to complete the form. One complained the form was too long and bad; two said the study had merit but they just didn't have the time; one said a budgetary crisis prevented them from answering any surveys.

1 Forgot to mail the form back.

1 A family counseling approach failed; staff returned to their regular counseling assignments.

Continuation of this activity was pointless. We weren't learning enough to warrant additional investment.

Table II-3
PROFILE OF SITE VISITS

Project	State	Locale Served	Type of Program	Current Funding	Ever have LEAA Funds? Yes	Ever have LEAA Funds? No	Annual Budget	Professional Staff? Yes	Professional Staff? No	External Evaluation Yes	External Evaluation No	Juvenile or Adult Offender	Family Counseling the only Service? Yes	Family Counseling the only Service? No	Other Services	Start Date	Therapeutic Approach (if known)	Region
Hereford Family Services Center	TX	Rural	Small community mental health center; support services to court and probation	State; county; client fees		X	$ 74,000	X		X		Both		X	Individual counseling; parenting education	1973	Minuchin	SW
Family Renewal Center	MN	Range	Incest treatment	Federal; client fees	X (indirect)		$250,000	X		X		Adult		X	Group counseling and support; psychoeducation	1978	Family systems; addiction model; comprehensive therapeutic milieu	PL
Family Counseling Center	VA	Urban	Court-based status offender diversion	LEAA; state	X		$131,000	X			X	Juvenile	X			1976	Bowen; Minuchin; Haley	SE
Brockton Comprehensive Counseling Program	MA	Small urban	Community-based diversion project	State		X	$225,000	X and X		X		Juvenile		X	Individual counseling; alternative school	1977	Non-structured; support-oriented	NE
Southern Connecticut State College FC Center	CT	Small urban	Training program for family counselors	State; LEAA	X		approx. $ 26,000	X			X	Juvenile	X			1978	Minuchin; gestalt	NE
El Nido Services	CA	Urban; Suburban	Juvenile offender diversion projects	LEAA; other federal; state; local	X		approx. $500,000	X		X		Juvenile		X	Individual counseling; group support	1974	Systems and individual psychodynamics; eclectic	FW
Lane County Juvenile Court	OR	Range	Court-based juvenile offender diversion	County		X	$ 58,000	X			X	Juvenile	X			1974	TA, PET, and Dreiker utilizing co-counseling	FW
Barrio Youth Project	AZ	Urban	Hispanic youth services	LEAA; city	X		$779,000	X			X	Juvenile		X	Vocational programs; tutoring	1969	Support oriented multi-cultural emphasis	SW
Delaware County Juvenile Court	PA	Range	Court-based for delinquents	County	X		$ 30,000	X			X	Juvenile	X			1972	Eclectic with structural emphasis	NE
Greenbelt Cares Youth Service Bureau	MD	Small urban	Youth service bureau diversion	City; state	X		$ 78,000	X and X		X		Juvenile		X	Job bank; tutoring; parent groups	1973	Behavior modification	NE
Family Therapy Teams District III	IA	Range (6 counties)	Department of social services; community based teams	State	X		$ 95,000	X		X		Both	X			1976	Systems theory; Minuchin; behavioral	PL
Youth Services of Oklahoma Co., Inc.	OK	Suburban	Youth and family counseling agency; delinquency prevention program	State; federal; city; private	X		$502,000	X		X		Juvenile		X	Individual short-term and crisis counseling; shelter	1972	Crisis-oriented brief; eclectic	SW
Pacifica Youth Service Bureau	CA	Small urban	Youth service bureau diversion	County; city; schools	X (indirect)		$113,000	X		X		Juvenile		X	Group and individual counseling psychoeducation in schools	1969	Short-term; problem-oriented; behavioral	FW
Bill Wilson House	CA	Suburban	Shelter care	LEAA	X		$111,000	X			X	Juvenile		X	Individual counseling; group counseling	1977	Minuchin; behavioral; communications	FW
Western Ohio Youth Center	OH	Small urban; rural	Residential treatment for delinquents	Federal; state; county; client fees	X		$285,125	X			X	Juvenile		X	Individual counseling; group counseling; recreation program; education program	1975	Behavioral; environmented treatment	GL
Family Diversion Center	IL	Suburban	Sacramento-type status offender diversion	County	X		$170,000	X			X	Juvenile	X			1975	Task oriented, intensive, Sacramento	GL
Family Therapy Institute	MD	Statewide	Residential treatment for status offenders and delinquents	LEAA	X		$273,000	X			X	Juvenile	X			1978	Intensive short-term residential treatment for entire family; eclectic strategy	PL
Salt Lake Youth Service Center	UT	Urban	Status offender diversion	County; state; federal	X		$334,000	X			X	Juvenile		X	Parent education; group counseling; shelter	1974	Short-term; eclectic	RM

9/23/80

AMERICAN INSTITUTES FOR RESEARCH
P.O. Box 1113, Palo Alto, Ca. 94302

III. Analyses

A. Development of Models

We constructed prototypic rationales that served as templates of family counseling activities. A rationale formally represents the network of assumptions that underlie a group of family counseling projects. It sets out the intervention strategy as a flow diagram that portrays the links between inputs, activities, immediate or short-term outcomes, and anticipated long-term impacts. These rationales were reviewed by the on-site practitioners and program directors to determine the similarities shared between the prototypic rationales and the programs-in-place. We also noted the existence of program characteristics unique to a site. One concern was the plausibility of a model with respect to the internal logic and the external linkages; a second was the extent to which the tentative models captured a realistic view of family counseling. This information guided the development of one or more models that represented the family counseling domain within the criminal justice system. The models could then serve as the basis for organizing and classifying data from the mail survey.

The desirability of organizing the data around conceptual models received support from the family counseling practitioners who confirmed our early notions about the enormous range of activities conducted under the family counseling label. Many further suggested that a uniform definition of family counseling activities with criminal justice clients would not only be difficult to construct but of little utility. We learned more about what activities occur in an agency that purports to focus on family interventions; agencies often provide multiple services in addition to the family counseling. One of the major concerns of the practitioners was the extent to which family counseling was the primary or only treatment offered. Indeed, in our site visits, we did see agencies where families were referred elsewhere if whole-family participation could not be achieved. In other sites, the counselors would work with any willing family member(s), and the agencies provided a wide range of services in addition to counseling activities. This led to some flexibility in applying our original criteria of whole-family involvement in the intervention, and the relationship between family counseling and other activities.

We derived three general models that stress common elements within each and reflect a <u>continuum</u> of family intervention, from least to most:

1. One model offers multiple services to multi-problem families, where family counseling may not be a primary focus. The clients tend to be low-income, often single-parent families, with insufficient or inappropriate coping skills. Their needs are as basic as food, shelter, medical care, and legal assistance. Agencies in this model tend to have resources within the agency to help the family with survival needs in addition to dealing with psychological problems among family members. A client-family will often receive

agency services over a long period of time. If Maslow's hierarchy has any merit, it is most clearly demonstrated in this model, where a family struggling to survive is unlikely to be receptive to therapy. The agencies in this model recognize and react to this problem. However, only two agencies were visited that had all of these characteristics, and were uncertain whether they represented a unique model. We called them Model I agencies.

2. Another tentative model seemed to focus on skill acquisition and development--parent effectiveness training, communication skills, conflict resolution, and problem solving skills. "Homework" assignments and contracts were common. For example, at one site visited, the parents of a boy who "can't do anything right" were sent home with the assignment that they must praise him twice before they were "allowed" to criticize him once. Crisis intervention and problem management also seemed to be important aspects of this model, which we called Model II.

3. A third model included sites where family intervention was the sole or primary approach, designed to bring about change in the family system. The therapist develops a "diagnosis" of family functioning, a set of short and long-term treatment goals, and may escalate stress to alter deeply ingrained dysfunctional family patterns. We named these agencies Model III.

These models were discussed in a meeting of an advisory work group (representing family therapy, criminal justice, and evaluation) who generally endorsed our conceptions.

B. Infusion of the Survey Data into the Models

This procedure can best be characterized as iterative: we began with a global assessment of the questionnaire data with respect to the models, then progressed through a sequence of steps that led to clarification of the features which distinguished each of the models.

1. Applying global assessment. As project staff members coded survey data from the questionnaires, each person tried to assign a model type to the questionnaire. The rationale for this judgment was to represent a combined knowledge of the overall impression of the agency based on the item responses and the staff member's familiarity with each model. Each person assigned about 30 questionnaires to one of the models, but the results were unsatisfactory. The differences were not clearly definable, and we gained little understanding of the coder's idiosyncrasies in assignment. We terminated this procedure--it was of little value.

2. Examining family counseling as only a primary treatment. We searched for distinguishing features among the distributions of the survey data to try to identify "scores" that could relate to the three models. One analysis involved classifying the sites into three groups depending upon the response to questions dealing with the percent of clients who

receive family counseling as the sole or primary treatment. One group included sites where 80 percent or more received family counseling as the sole or primary treatment; another group included sites where 60-79 percent received such treatment; and a third group where less than 60 percent received such treatment. This variable proved useful as a sorting mechanism for exploring other potential model features, but not as the only criterion for model assignment.

3. Exploring other variables. Responses to other questions were examined across these three groups, in a search for other variables that fit the tentative models. This exercise was not highly rewarding; the overlap in the distributions seemed too great to warrant further pursuit of using this single variable--percent receiving family counseling--as a major indicator of models. However, we were able to identify from the distributions a few more "leads" for identification. The sites that had family counseling as a secondary activity seemed also to provide many more non-counseling services, to have the families in attendance longer, and to be part of some type of community program. This is logical, of course, since the clients have many problems, most of which are long standing, and their needs cannot be met by counseling alone. These agencies seemed to fit Model I.

The sites that used family counseling as the sole or primary approach seemed to be identifiable by a dearth of other services; and by variables reflecting the whole-family approach: identified patient present at intake, both parents at intake, and interviews with all family members. These characteristics seemed compatible with model III.

Model II agencies emerged less distinctly, but a few characteristics were suggested. Among the direct services, we identified parent education; types of agencies seemed to be represented by youth-serving agencies, and those offering short-term counseling.

4. Assigning questionnaires to models: round two. Using the guidelines specified in the preceding section, three senior staff members independently reviewed all questionnaires and classified them according to models. The results were: 40 percent unanimous agreement among the raters; 59 percent agreement by two raters; and one percent, no agreement. Overall percent of agreement was 79 among the three raters.

The staff discussed the disagreements by reviewing the questionnaires and indicating on what basis they had made a particular assignment. While there was considerable agreement on several variables, individual staff members were differentially influenced by other variables. For example, for one staff member the use of volunteers or many paraprofessionals seemed to be more characteristic of Model I, for another, the presence of a budget for training seemed to be a Model III indicator. This was generally the type of reason for the "misclassifications."

5. Selecting model indicators. To clarify further the variables which seemed to describe Models I and III, we examined the questionnaires of a sample of each model on which there was unanimous agreement among the three

raters.* We sought indicators that seemed to be most characteristic of these models and that showed little or no overlap between the two samples of questionnaires. As each set of several indicator variables was proposed, a computer printout of the scores on those indicators was prepared. Examination of these printouts led to changes in the indicators, in some cases by changing the level of response to a variable; e.g., cutting at 90 percent positive response rather than at 80 percent, accepting more than one response to an item, etc. Also, some potential indicators of models were deleted because they appeared to be equally characteristic of all groups, and new ones were added.

After three such iterations no further improvement was obtained by manipulating additional potential indicators. For each indicator of Models I or III, a unit score was assigned to each agency, indicating whether the indicator was present or absent. The final set of indicators are presented in Table III-1.

Table III-1 Indicators Used to Score Mail Survey Questionnaires for Models I and III

MODEL I INDICATORS		MODEL III INDICATORS	
Indicator	Description	Indicator	Description
1	Characteristics of the Agency Model I is indicated if the respondent reported that the agency was a Community Program (Code 4), one of the options within the category called "Broad-based Mental Health."	1	Characteristics of the Agency Model III is indicated if the respondents reported under the category "Broad-based Mental Health" that the agency was one of the following: Family and Children's Services (Code 1), Community Mental Health Center (Code 2), Family Counseling Center (Code 5), Child Guidance Center (Code 6), or Individual Clinicians (Code 8).
2	Importance of Family Counseling Model I is indicated if 40 percent or more of the clients receive family counseling as a secondary component of treatment.	2	Research Model III is indicated if the agency is currently conducting research in family counseling, or has done so in the past.
3	Other Direct Services Provided Model I is indicated if any direct service other than counseling is provided as a primary component of treatment. This includes such services as tutoring, job placement, food/nutrition assistance, legal assistance, etc.	3	Testing Model III is indicated if the agency uses tests as part of the intake process.
4	Number of Counseling Sessions Model I is indicated if 60 percent or more of the clients have a total of at least 12 sessions.	4	Parents at Intake Model III is indicated if 90 percent or more of the pre-service assessment includes one or both parents of the IP.
5	Length of Association with Client Model I is indicated if 50 percent or more of the clients are receiving service for 12 months or longer.	5	Other Family at Intake Model III is indicated if any other family members are included in the pre-service assessment process.
6	Type of Program Model I is indicated if the respondent reported that the agency is a Community Youth Program. This is a Code 4 in the agency characteristic called "Youth-oriented."	6	Importance of Family Counseling Model III is indicated if 90 percent or more of the clients receive family counseling as the sole or primary component of treatment.
		7	Pre-service Interviews Model III is indicated if pre-service interviews are held with IP and with parents and/or other family.
Maximum score on Model I = 6		Maximum score on Model III = 7	

* We had more confidence in scrutinizing Models I and III because the raters disagreed on a very small number of questionnaires belonging to Model I or Model III.

All of the mail survey questionnaires were scored for both models, and a matrix was prepared displaying the agencies' Model I vs. Model III scores, the score being the number of indicators present in the agencies. Figure 1 illustrates.

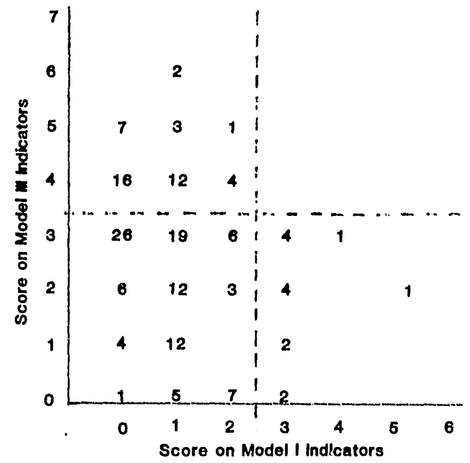


Figure 1.

Classification of Mail Survey Agencies by Scores on Models I and III

The agencies in the upper left quadrant should be those agencies that best fit our Model III; they have very few characteristics of Model I and score highest on the Model III indicators. Model I agencies would be those in the lower right quadrant, with the highest scores on Model I and relatively low Model III indicator scores. We were concerned about the four Model I agencies that actually had three indicators on Model III as well, so we re-examined those survey forms to determine whether they did indeed seem to be like the other Model I agencies. All of them seemed to us to be more like Model I. They acquired their Model III scores primarily on indicators 3, 4, and 5, which deal with persons present at intake and pre-assessment. Family counseling was less important as a sole or primary component of treatment, so these four cases were left in Model I.

Another area of concern were the 26 sites that had three indicators for Model III and no Model I indicators. These appear to be "near-misses" for Model III, so we believed it was important to determine whether these agencies "fit" Model III. Survey forms for each of these agencies were reviewed by senior staff members. The results of this analysis were interesting: these cases seemed to divide into two rather distinct categories. Nineteen of the cases were very similar to Model III, in terms of total commitment to family counseling, but they tended to lack either the research component or the intake testing component. These 19 cases were, we felt, similar enough to justify moving them into that model. We con-

firmed such a move by examining a printout of all the major variables according to Model I, Model II, Model III, and these 19 cases (Model III A). Models III and III A closely resembled one another more than III A resembled the other models on 13 out of 16 items; all 19 cases offer family counseling as the sole or primary treatment to 90 percent or more of their clients (a III indicator). We were confident a shift of Model III A to Model III would not jeopardize our analysis. We also re-examined the 19 cases which fell into Model III but scored 1 on Model I. We believed they could remain where they were.

The agencies that fell into the lower left quadrant of Figure 1 become Model II, by exclusion, according to the sorting based on Model I and Model III indicators. We examined these agencies more closely, to determine whether they could stand as Model II or serve as the basis for a new family counseling model.* In this analysis, we organized the cases into six subcategories, derived from their "indicator" score, for example, one group scored 2 on Model I and 2 on Model III; another group emerged with 2 from Model I and 3 from Model III--and so on. The analyses focused on the direct services provided to client-families. Service delivery is an agency's business, and we looked for emphasis or patterns among the subcategories that suggested a shift to another model or development of a new one. We found nothing compelling to justify alterations to the conceptual models.

Our final sorting resulted in Model I (N=14), Model II (N=82), and Model III (N=64).

C. Description of Models

As previously discussed, we initially devised three models from the site visit data. We also examined the mail survey data to amplify our understanding of the models and to provide a more complete profile. The following descriptions are based on both the site visit and mail survey data.**

Each model is presented with a narrative and a graphic representation called a "program rationale." The program rationale depicts the cause-effect relationship between family counseling activities and outcomes. The major assumption underlying the rationale is that if certain activities

---

* It is important to remember that the overall purpose of the models is to represent the domain of family counseling in a manner that permits some generalizability of the treatment modalities. The models illustrate relationships between inputs and outputs and provide hypotheses for subsequent assessment.

** These models represent a technique for incorporating a large volume of information about family intervention strategies into a common framework.

occur, designated outcomes and impacts will follow. The rationale is divided into five major parts:

1. Inputs: the resources necessary for the program to begin operation
2. Immediate Outcomes: the immediate and direct effect of existing inputs
3. Process: core services provided to families and the mechanisms for delivering these services
4. Intermediate Outcomes: the direct intended effects of program processes
5. Impacts: the long-term, intended direct and indirect effects of all inputs, activities, and outcomes.

1. Model I: The Comprehensive Services Approach. As the name implies in Model I family counseling plays an important role, but is not the primary focus. Client-families are typically low-income and/or minority populations. Many are female-headed families in which the identified client tends to be male.

Although these client-families are often in need of skills and services, they are isolated from the social service community. Because the parent's survival needs are so great, the parent is often unable to perform adequately in the parenting role. The law-violating youth is similarly seen as alienated from both community and family. Model I thus aims to reduce both intrafamily and community alienation.

Figure 2 presents the program rationale for the Comprehensive Services model. Two unique features are that the counseling facility is established within the targeted area and that the staff are often paraprofessionals with similar social, economic, and ethnic backgrounds as the clients.

The Comprehensive Services approach includes an intake and assessment procedure: an interview with the identified client and the parent(s).

Services are tailored to client needs and the treatment focuses on the establishment of a trusting counselor-client relationship. This relationship is not necessarily terminated with the completion of "structured" family counseling sessions. Quite often the relationship continues on an informal basis for an extended period. Treatment frequently lasts for over a year. In addition to family counseling, a variety of other services are provided such as individual counseling, job counseling, advocacy services, enrichment activities and legal assistance. Although the staff do not have extensive formal education or training, they do receive a great deal of on-the-job training and supervision.

The Comprehensive Service approach aims to improve family functioning, increase the self-sufficiency of the family, reduce or extinguish the presenting problem and increase family members' self-esteem.

Long-term goals include maintenance of the family unit, prevention and reduction of recidivism, increased family assimilation in the community and overall improvement in the family's quality of life.

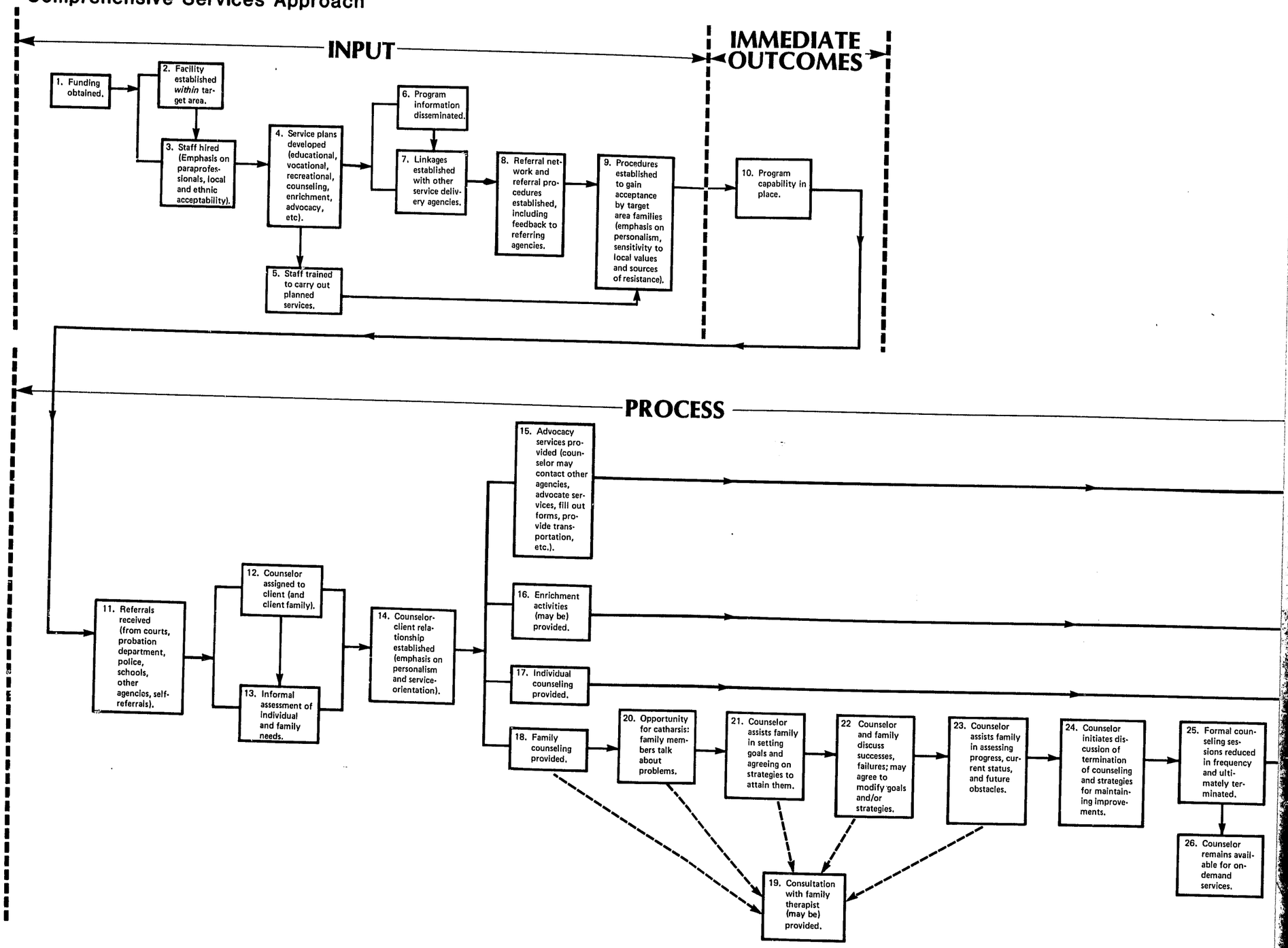
Model I programs are relatively new: No Model I program in our sample began before 1970. They report the influence of various legislation on their program and tend to receive most of their funding from state and local sources. Some Model I programs are group homes used as alternatives to incarceration of the youth. The greatest problem reported by these agencies is the difficulty in getting families to accept any kind of counseling.

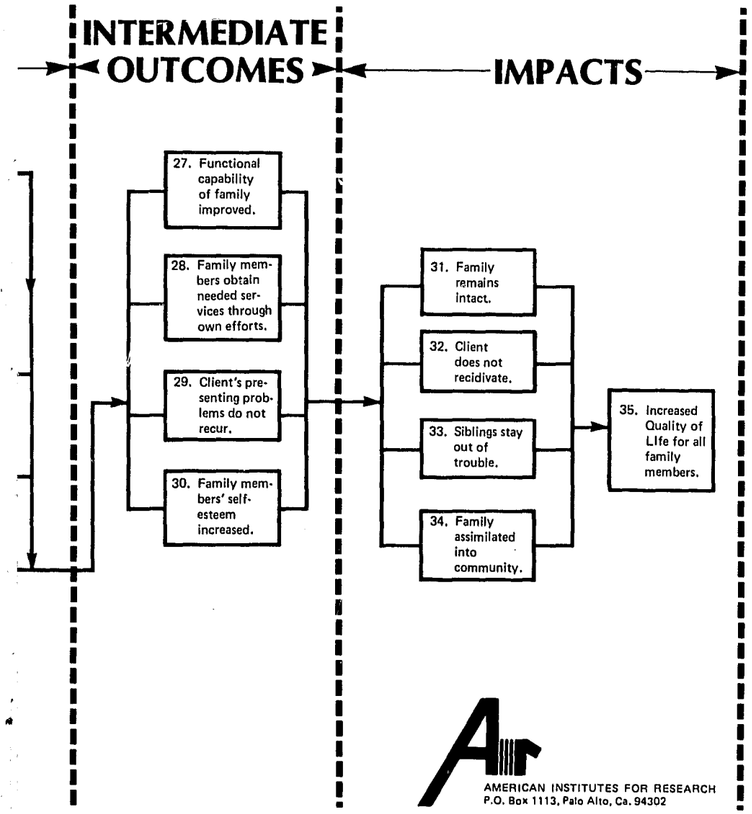
An example of a situation addressed by Model I agencies appears below.

At age 15, Tim was picked up for breaking and entering and armed robbery. He was referred to a community-based agency for treatment. Tim received individual counseling while continuing to live at home. Tim's mother, Rose Jenkins, was single, an alcoholic, and on welfare. Tim was one of her ten children, several of whom manifested problem behaviors ranging from prostitution to drug dealing and gambling; one sibling had been institutionalized. The household was comprised of thirteen to fourteen people: violence was a common occurance.

The counselor assigned to the case was a former client of the agency. Her first task was to gain the family's--particularly Rose Jenkins'--trust. She visited the household daily for several months, chatted with Rose and whoever else happened to be at home, helped to settle conflicts, provided Rose with transportation, and assisted her in dealing with social service and law enforcement agencies. Eventually Rose was willing to discuss family problems, and the counselor helped her to work toward some specific goals such as decreasing her drinking and working with the family to find less violent ways of dealing with one another. Rose also joined a support group of other mothers who were clients of the agency.

Comprehensive Services Approach





AMERICAN INSTITUTES FOR RESEARCH
P.O. Box 1113, Palo Alto, Ca. 94302

2. Model II: The Family Management Approach. In the broadest sense, this model represents the interface between counseling and education. Perhaps the most notable feature is the focus on skill acquisition within a time-limited, structured counseling framework. Considerable effort is spent developing parenting skills, communication skills, conflict resolution and problem solving skills.

Figure 3 presents the program rationale. Program inputs include staff development activities and the establishment of service and referral procedures resulting in program capability and community/juvenile system recognition.

Services in the family management approach often begin with both crisis counseling or temporary shelter for a juvenile to alleviate a critical event such as running away from home, shoplifting, or truancy. Following crisis intervention activities, intake procedures begin which include an interview with the youth and parents, and if possible, other family members. The family and counselor set treatment goals and proceed toward goal accomplishment.

Therapeutic goals are typically narrow and focus on the management of specific family, child, or parent-child behavioral tasks for each family member. The arrangements may be formalized with a contract or series of "homework" assignments.

During the course of treatment, family members may meet with the counselor alone or in various family member combinations. Because parents are viewed as the major influencers on child behavior, Model II family counseling emphasizes and supports the authority and management role of the parents and provides parent education. Although counselors are actively involved in the treatment process, the effectiveness of the family management approach is not viewed as contingent upon the development of an intense counselor-client relationship. Termination usually begins when the counselor and the family reach agreement on goal accomplishment. After termination, family members may continue with ancillary services, usually from another agency. Treatment usually lasts between 3-5 sessions.

The family management approach aims to resolve the presenting crisis, increase family stability, and increase constructive individual and family skills. Long term goals include improved quality of life for family members, improved family functioning, reduced recidivism, reduced out-of-home placement and increased diversion from the juvenile justice system with the use of whole-family oriented services.

Model II programs tend to be of recent origin: almost half were founded in the past five years. They are located in various geographical regions ranging from metropolitan and suburban areas to rural areas.

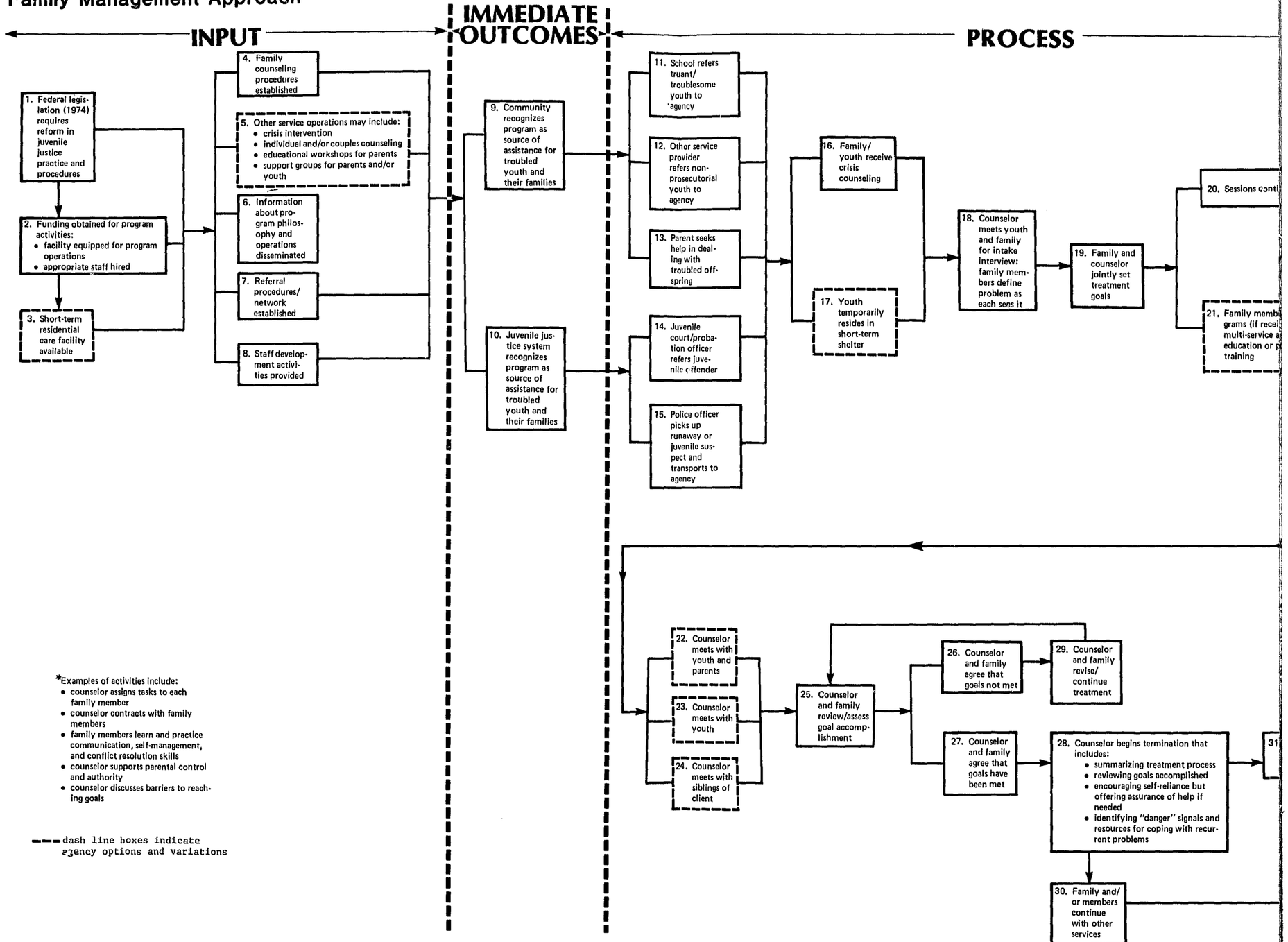
Funding comes primarily from state and local governmental sources, particularily monies targeted for juvenile diversion programs. The greatest problem reported is the difficulty in engaging clients in family counseling.

An example of clients served by Model II agencies appears below.

Melanie, aged 15, was the only child in a household with her mother and stepfather. The girl and her parents fought constantly, and eventually Melanie ran away from home for a few days. When she returned, her parents turned her over to the police who in turn referred her to the local youth services agency. During the intake session, Melanie complained that her parents were too protective and their standards for her were too high; they countered that she was irresponsible and had a bad attitude. The counselor suspected that they wanted to have Melanie placed in a foster home. However, the family agreed to attend six counseling sessions to see if they could resolve their crisis.

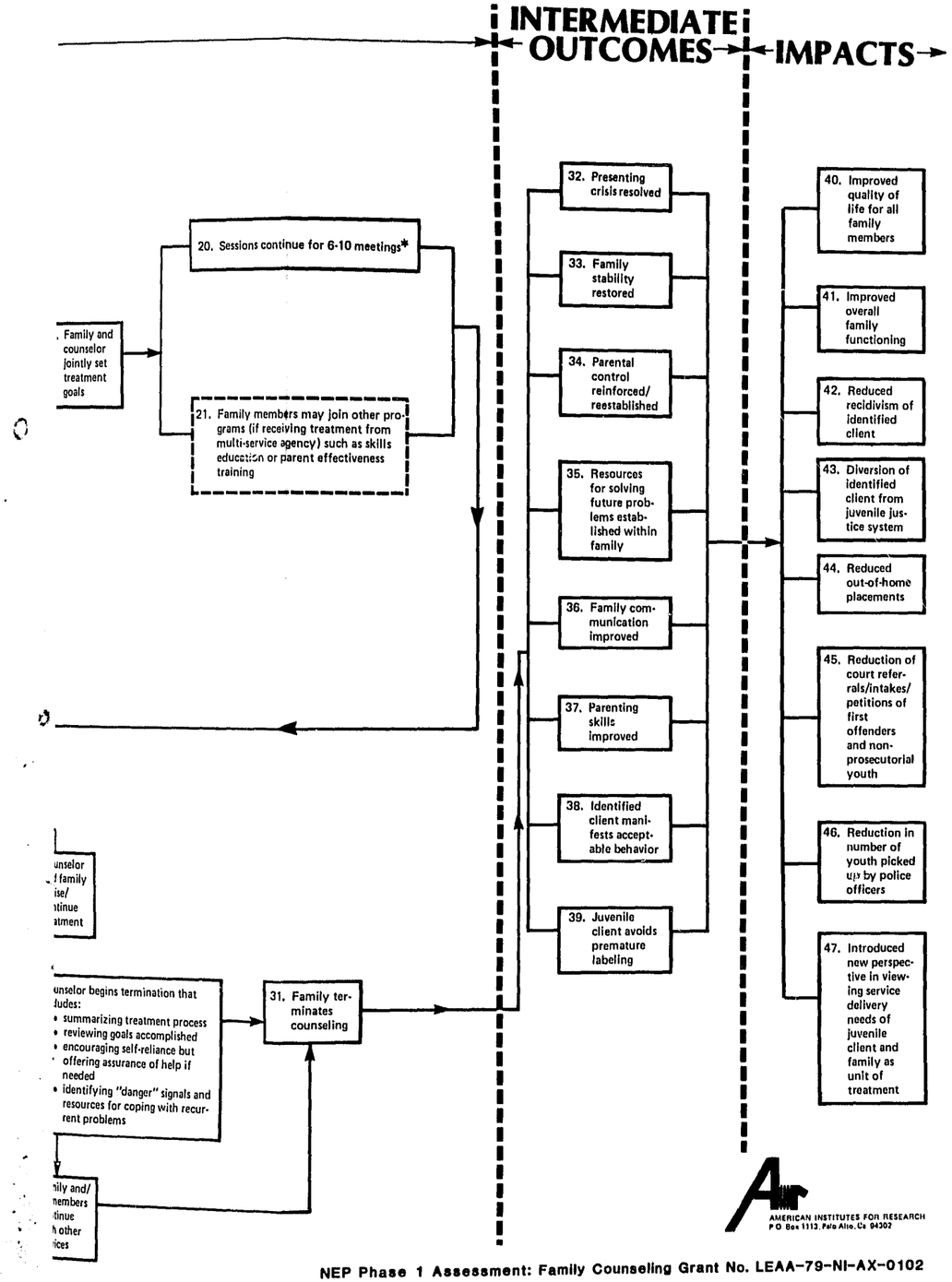
Aside from one 20-minute consultation with Melanie, all sessions involved the three family members. The focus of discussion was Melanie's desire to quit school, which she was failing. Her parents were helped to understand that they were projecting their own needs onto their daughter, and the family was helped to negotiate a settlement of the issue: Melanie could quit school for the remainder of the year if she could find a job. In the fall, her parents would reconsider the arrangement. Thus the immediate crisis was resolved and the counselor hoped the family could manage similar disagreements in the future.

Family Management Approach



*Examples of activities include:
- counselor assigns tasks to each family member
- counselor contracts with family members
- family members learn and practice communication, self-management, and conflict resolution skills
- counselor supports parental control and authority
- counselor discusses barriers to reaching goals

---dash line boxes indicate agency options and variations



NEP Phase 1 Assessment: Family Counseling Grant No. LEAA-79-NI-AX-0102

3. Model III: The Family Restructuring Approach. This model uses therapeutic strategies to promote systemic family change and to alter family rules, roles and coalitions. Figure 4 presents the program rationale. Formal family therapy training is often provided at the outset and many staff report attendance at specialized workshops. A large number of counselors have advanced graduate degrees in counseling or related fields. Like the other models, service and referral procedures are established which enable the program to begin operation.

The intake procedure almost always involves the identified client and his/her parents: other family or household members may also be present. The intake procedure includes an assessment of individual, family subsystems (i.e. marital, sibling or parent-child relationship), and whole family system dynamics. In some cases, family counseling sessions are videotaped or directly observed by other professionals. A referral person may also participate.

Based on an observation of family interaction and dynamics, the counselor develops a diagnosis about the family's functioning, hypothesizes about the dynamics that create and maintain the family's functioning, and uses this information to develop treatment goals. A variety of intervention strategies are used to accomplish the treatment goals. These include escalating stress in the family to alter dysfunctional family interaction patterns, relabeling problems, modeling and "teaching" communication skills, examining and challenging family rules, roles, positions and coalitions, promoting individual insight, working with family subsystems such as the marital or sibling relationship, and providing parent education. These strategies are implemented with a variety of techniques such as paradox, family sculpting, use of metaphor, art, movement, role-playing, and skills training. Case progress is usually discussed and decisions are often made in consultation with other professionals.

The termination sessions usually involve a review of goal accomplishment and an identification of unmet treatment needs. The therapist may predict possible relapses, suggest ways to avoid them and refer family member(s) to other service providers. Treatment frequently lasts as long as one year.

The family restructuring approach aims to increase family members' awareness of their behavior, increase responsibility for one's own actions, develop more appropriate roles and coalitions and bring about some intrapsychic change. Additionally, this model aims to improve family communication and problem solving, strengthen the parental and marital subsystem and alleviate the presenting problem.

Long-term goals include reduced recidivism and out-of-home placements; family system alteration and improved family functioning; improved quality of life for all family members, in symptom substitution and reduced repetition of similar problems in future generations.

Model III programs tend to be located in metropolitan, suburban, and some rural areas. They have been in existence longer than programs in the other models: more than one-third were founded before 1960 and over half were founded almost a decade ago. Like the other models, these programs get most of their funding from state and city sources. However, in more recent years many received LEAA funds.

A small percentage of these programs include a residential component. Most identify themselves as family counseling centers, family and children's services, community mental health centers, or youth service bureaus. The greatest reported problem is the difficulty in engaging clients in family counseling.

An example of a Model III situation follows:

The school counselor (after conferring with the student, then the mother) referred a family to the local family counseling center. He based the referral on the daughter's misbehavior in school, occasional running away from home, and truancy. The daughter was 13: her sibling was a 15 year old male. Eight sessions were conducted, all attended by the entire family. At the first session, the co-therapists explained the clinical procedures (observers behind one-way mirror, microphones recording the conversations, etc.) and each family member described his or her view of the problem(s). Therapists attempted to identify strengths in the family and its potential for working together. This family wanted to receive help, and listened closely to techniques such as the modeling of parents' communication, done by the therapists when the mother and father did not look at one another or speak directly to one another. Other strategies employed by the therapists included definition of the subsystem boundaries and physically relocating family members within the sessions. They also coached the family during the conversations, prompting and correcting to illustrate the therapists' points. The therapists decided when the family was ready to terminate.

Family Restructuring Approach

INPUTS | **IMMEDIATE OUTCOMES** | **PROCESS**

1. Funding obtained for program activities
   - Locate and equip facility
   - Place appropriate staff (family therapists, administrators, volunteers, etc.)

2. Disseminate information about program philosophy and operation

3. Train staff in family therapy techniques and theory (as required)

4. Create referral network: establish referral procedures (in and out of agency)

5. Program has capability to provide family therapy:
   - trained staff
   - adequate facilities
   - referral network
   - community awareness of service

6. Agency receives referral, usually from one or more of the following:
   - courts
   - police
   - probation
   - schools
   - social services
   - self

7. Client and family undergo screening and intake procedures, such as:
   - family interview
   - psychological assessment
   - development of treatment contract
   - orientation to treatment program
   - therapist contact with referral person
   - collection of data on family

8. Family deemed appropriate for treatment program (usually by therapist and peers)

9. Family deemed inappropriate for treatment program (usually by therapist and peers)

10. Family may:
    - be referred to another service provider
    - be referred back to original referral source
    - drop out of referral process

11. Family therapy initiated
    Therapist activities:
    - establish role as helper and leader
    - support family in order to gain their trust
    - challenge family in order to create motivation for change
    - gather information about presenting problem and family history
    - redefine presenting problem in terms of family system
    - observe family interaction and dynamics including marital relationship, sibling relationships, and parent-child relationships

    Client family activi
    - describe prot see them
    - describe fami
    - explore and i for family th
    - accept therap
    - establish cor enter therapy

12. Supplementary techniques may be used:
    - family therapy session videotaped
    - family therapy session observed by other professionals behind a one-way mirror
    - referral person participates in session

13. Therapist diagnoses family functioning

14. Therapist develops hypotheses about family dynamics

15. Therapist develops treatment goals

16. Family therapy continued. Attempt to accomplish treatment goals by doing some or all of the following:
    - Escalate stress in the family to alter its tendency to maintain dysfunction
      - highlight areas of disagreement among family members
      - alter usual communication flows
      - form coalitions with family member(s)
    - Examine family problem and relabel it in terms of family systems
    - Model clear communication and affect
    - Explore and challenge family rules (both overt and covert rules)
    - Examine and challenge family roles, positions, and coalitions
    - Direct family members toward insight into their family system
    - Work with the marital relationship when appropriate
    - Work with the sibling relationship when appropriate

17. Techniques used may include:
    - sessions videotaped
    - sessions observed by other professionals behind a one-way mirror
    - referral person participates in therapy sessions

18. Therapist reviews and discusses case with colleagues/ supervisor (ongoing process)

19. Therapist discusses with referral person (may be ongoing)

20. Treatment strategy/ goals reviewed—revised if necessary

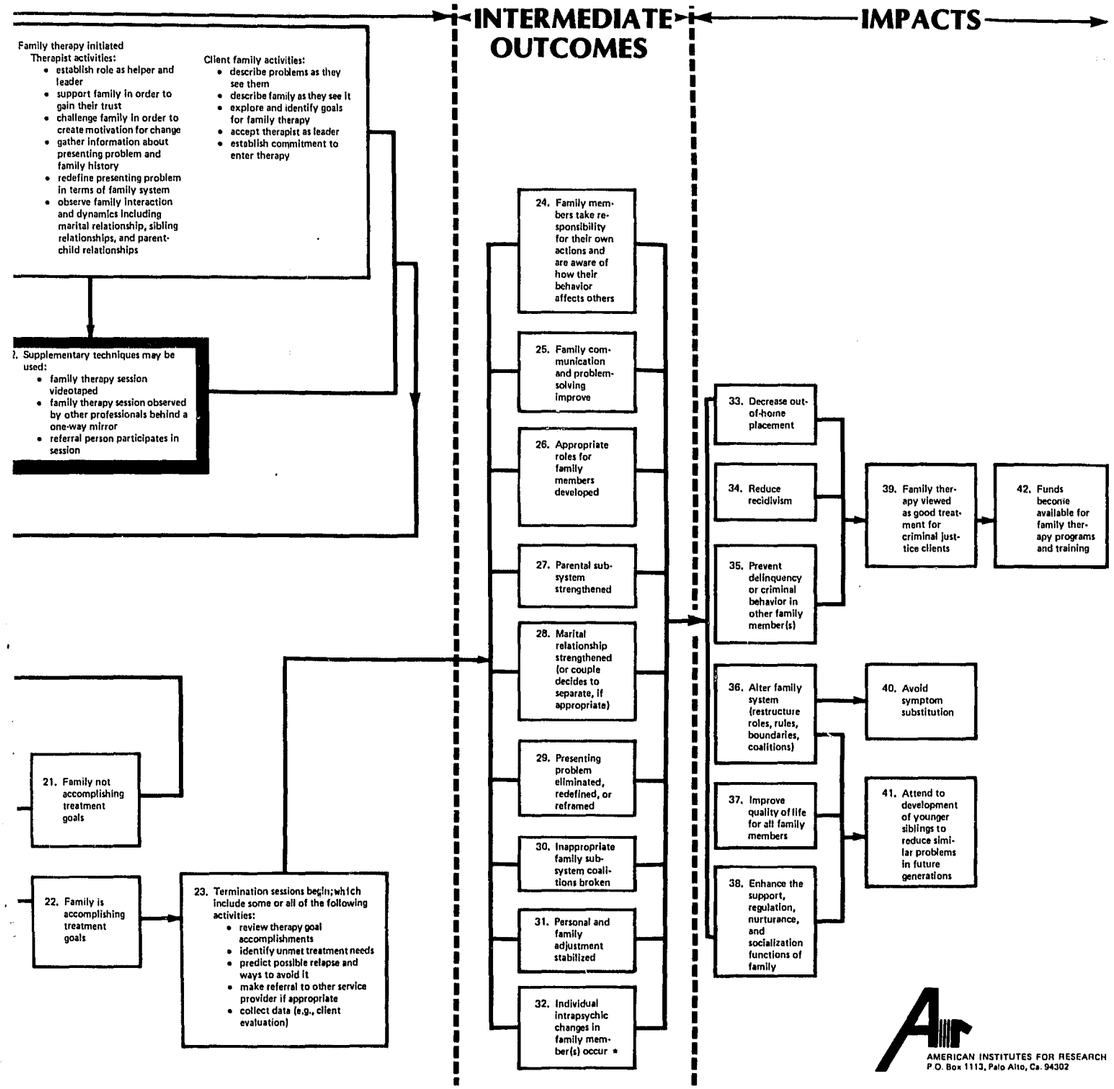
21. Family not accomplishing treatment goals

22. Family is accomplishing treatment goals

23. Termination sessi
    Include some or a activities:
    - review there accomplish
    - identify unr
    - predict poss ways to avo
    - make referr provider if
    - collect data evaluation)

Screened boxes represent agency options. Selections vary by agency.

* *Note:* Various techniques used which may include: paradoxical interventions; communication and problem solving skill training; parenting skills training (informal); art; movement; metaphor; sculpting; role playing.



AMERICAN INSTITUTES FOR RESEARCH
P.O. Box 1113, Palo Alto, Ca. 94302

NEP Phase 1 Assessment: Family Counseling Grant No. LEAA-79-NI-AX-0102

IV. Findings

In this chapter, we present the findings of the study and discuss some implications suggested by the data. We aim to direct attention on the issues related to a specific treatment modality applied within a given context.

A. Model Characteristics

Now we will indicate characteristics of the models which seem to differentiate them. It must be remembered, however, that all projects share some commonm features, since they strive to reduce incidence of delinquent behavior by applying principles of family counseling. The selection criteria were intended to produce some homogeneity. The resources and constraints on the agencies, and the way they go about meeting their goals do, however, result in some differences among models. These differences will be highlighted in the following pages, but we caution the reader to bear in mind that only 14 programs were labeled Model I, so percentages for this model may be unstable.

1. Caseload. As with most descriptive variables, all models are represented in nearly the full range of caseload frequencies. Model I tends to handle a smaller caseload than the other models. This is not unexpected since they deal with families in need of many services in addition to counseling, and since frequent home visits may be required just to establish a level of trust and functioning that would make the family receptive to going somewhere for counseling. The modal caseload for Model I is in the 26-50 per year range, compared with 151-250 for Model II and 51-100 for Model III. The larger caseload for Model II is consistent with its focus on resolution of a current family crisis and the relatively short period of time over which counseling takes place.

Table IV-1 Annual Caseload, by Model

	I		II		III	
	N	%	N	%	N	%
1-25	1	9	6	8	3	5
26-50	3	27	9	12	6	11
51-100	1	9	11	15	15	27
101-150	0	-	5	7	11	20
151-250	2	18	15	21	7	13
251-350	2	18	6	8	6	11
351-550	0	-	10	14	3	5
550	1	9	10	14	4	7
Omit*	4		10		9	

*Omits not included in percents.

2. Funding. All models have programs operating at various funding levels. Model II had the highest average funding level during the survey year.

Model	No Data	N	Average funding level, 1980
I	2	12	$426,170
II	20	62	$613,294
III	21	43	$303,088

Note that the number of cases in each model is incomplete because not all respondents provided information on dollar amounts of funding. In all models there appear to be two classes of programs--about half of them operate at $150,000 or less, and another 25 percent at budgets of over $350,000. The lowest budget program was a Model I, at $3,000, compared with a low of $12,334 for Model II, and $15,295 for Model III.

Money to operate the programs comes from a number of sources. Only 30 percent of the programs receive money from only one source, and a few from 7-9 sources.

Table IV-2

Number of Sources Providing Funds, by Model

	I		II		III	
	N	%	N	%	N	%
One	4	29	30	37	14	22
Two	4	29	21	26	23	36
Three	4	29	14	17	7	11
Four	2	14	6	7	13	20
Five	0	--	8	10	3	5
Six	0	--	0	--	0	--
Seven	0	--	0	--	1	2
Eight	0	--	1	1	0	--
Nine	0	--	0	--	1	2
Omit*	0		2		2	

*Omits not included in percents.

These sources include money that may come in relatively small amounts, as from local private donors and fees charged to clients. Such fees are often based upon an ability-to-pay scale, sometimes as little as fifty cents per counseling session.

LEAA has been a strong contributor to family counseling programs. As seen in Table IV-3, nearly four out of five programs have at some time received funds from LEAA, and the proportions are approximately equal for all models.

Table IV-3 Number of FC Programs Funded by LEAA

	I		II		III		All Models	
	N	%	N	%	N	%	N	%
Never funded by LEAA	3	21	16	20	14	23	33	21
Past and/or present LEAA funding	11	79	64	80	48	77	123	79
Omit*	0		2		2		4	

*Omits not included in percents.

Funding by LEAA has not been at the same level across all models, though this may be only an apparent difference because of the number of agencies that did not provide data.

Table IV-4 Total LEAA Funding, All Years, by Model

	I		II		III	
	N	%	N	%	N	%
$ 51,000	0	--	8	19	7	20
$ 51,000-100,000	4	57	13	30	9	26
$101,000-150,000	0	--	5	12	7	20
$151,000-200,000	1	14	7	16	6	17
$201,000-250,000	1	14	2	5	1	3
$251,000-300,000	1	14	2	5	1	3
$301,000-350,000	0	--	0	--	0	--
$350,000	0	--	6	14	4	11
Omit*	7		39		29	

*Omits not included in percents.

Data are available for only 7 of the 14 Model I programs, but over half of them have received $51,000-100,000 from LEAA, and none has received more than $300,000. The patterns of funding of Models II and III are similar to each other, with large sums received by a few agencies. LEAA continues to be an important source of funds for family counseling; 57.7 percent of the agencies participating in the mail survey were receiving such funds in the survey year. A number of them commented on their dependence on this source of funds, and during the site visits we were told by program directors that continuation of services depended largely upon money from outside sources. A few have become line items in the state or county budget, but most agencies operate on soft money.

Other sources of funds reflect the diligence with which agencies have sought funding opportunities. This list is long, including youth development programs, drug related and mental health programs, Title XX, HUD, Head Start, CETA, and state, county, and local sources. Because only one or two

programs were funded by some of these sources, we have categorized the sources. They are shown in Table IV-5.

Table IV-5 Funding Sources of FC Programs, by Model

Source	I N	I %	II N	II %	III N	III %
Federal Government, LEAA	5	16	35	19	25	16
State, County Law Enforcement	5	16	19	10	22	14
Other Federal	6	19	28	15	18	11
Other State, County	11	34	64	35	54	34
Private	4	12	18	10	22	14
Fees, payments	1	3	10	6	13	8
Other	0	--	9	5	4	3

The patterns of funding are essentially similar across the three models. The highest contribution comes from the state or county, through law enforcement or other channels. This is a positive sign, since permanent funding is most apt to come from these sources. LEAA funds have time limitations, and unless the state or county takes over a program, its survival is unlikely.

3. Age of Program. Some of the family counseling programs have been in operation for over 20 years; others were in their first year of operation at the time of the survey. The older agencies were probably not conducting family counseling as we know it now in their earlier years, since it is a relatively new approach. Whether family counseling is an additional function or a change in therapeutic approach cannot be ascertained from the data. Table IV-6 presents the data on age of the different models.

Table IV-6 Age of Programs, by Model

Year Funded	I N	I %	II N	II %	III N	III %
Before 1960	0	--	6	7	13	21
1960-1969	0	--	7	9	7	11
1970-1971	4	33	11	14	8	13
1972-1973	3	25	14	18	8	13
1974-1975	3	25	9	11	9	14
1976-1977	0	--	17	22	11	17
1978-1979	2	17	15	19	7	11
Omit*	2		3		1	

*Omits not included in percents.

Model III agencies are clearly the oldest; nearly a third of them were in operation before 1970. On the other hand, none of the Model I agencies was in operation before 1970. Model II agencies are more variable, but

they show an increase in the last four years: 41 percent began in 1976 or later.

4. Population Served. Tables IV-7 and IV-8 show the size of the population and the geographic regions served by the different models.

Table IV-7 Size of Population Served

Population	I N	I %	II N	II %	III N	III %
Less than 2,500	1	7	0	--	1	2
2,500-10,000	1	7	3	4	1	2
11,000-25,000	0	--	3	4	2	3
26,000-70,000	4	29	11	14	10	16
71,000-100,000	7	50	44	56	30	49
More than 100,000	1	7	17	22	17	28
Omit*	0		4		3	

*Omits not included in percents.

Table IV-8 Geographic Areas Served

Area	I N	I %	II N	II %	III N	III %
Central City	1	8	7	9	1	2
Metro area	3	25	11	15	13	20
Suburbs	3	25	17	23	15	23
Rural	1	8	11	15	7	11
County	1	8	8	11	8	12
Other (mix of above)	1	25	21	27	20	32
Omit*	3		7		0	

*Omits not included in percents.

Only one agency in Model I serves a population of more than 100,000. Models II and III are about equally represented in the high population centers, though all models appear most frequently in the 71,000-100,000 size community. Models II and III are also more apt to serve rural areas than Model I, perhaps because rural areas are less likely to have the numerous ancillary services that are characteristic of Model I. That model seems to serve a moderate size city and its suburbs; Models II and III have larger catchment areas.

This geographic or community context within which family counseling services are provided deserves mention. Overall, the relationship between environmental and family variables with respect to delinquent behavior has been almost ignored, but those who do recognize and examine such frames of reference (e.g., Johnstone, 1978) suggest a crucial link and one that

warrants further study. From our perspective, such knowledge ought to guide the types of family counseling provided within specific communities. For example, if family functioning influenced a particular type of criminal or delinquent behavior, then the offense patterns in a community ought to be considered prior to offering a particular type of service.

5. Residential Component. Although only 36 percent of the agencies surveyed had a residential component, Model I was more frequently represented on this variable; 46 percent, compared with 39 percent for Model II and 30 percent for Model III. Consistent with their shorter period of counseling, Model II residential centers tend to keep their clients for a shorter period of time--about half of them for less than 15 days. Model I is more long term, with one-third of the clients in residence for six months to one year. However, none of the Model I agencies reported residential treatment for more than one year. Model III, although it had the lowest frequency of residential treatment, had the longest period of residency, 19 percent staying for over one year.

Clients in Model I residential centers are less apt to be there on a voluntary basis than are clients in other models: 67 percent of the Model I clients are non-voluntary, compared with 22 percent for Model II and 25 percent for Model III. Naturally, more of the Model I clients are in residential treatment as an alternative to incarceration, as shown in Table IV-9.

Table IV-9 Purpose of Stay in Residential Center

	I		II		III	
	N	%	N	%	N	%
Temporary removal from home	0	--	10	37	8	47
Alternative to incarceration	2	40	3	11	1	6
Intensified counseling	0	--	5	18	5	29
Other	3	60	9	33	3	18

For Models II and III, the most common reasons for residential treatment are for temporary removal from home and to intensify the counseling; neither of these is involved for Model I. Residential treatment as an alternative to incarceration suggests more serious police involvement, and while the N's in Table V-9 are very small, Model I agencies have more drug or alcohol related, and other cases, for which incarceration may indeed be the only other option.

6. Documentation. The questionnaire asked for a report of the types of data collected and summarized, and to whom summary reports were sent.

Voluminous data are collected by almost all agencies. Information maintained in the records typically includes: referral source; demographics of identified patient, such as age, offense record, ethnicity, sex, education, presenting problem; family composition; date of initial contact; number of contacts; length of service; treatment goals; services provided and referred elsewhere; case notes; reasons for termination; and follow up data.

Much of these data are potentially useful for evaluation purposes, as we discuss in the final section of this report. What is currently missing is a systematic documentation of the data (e.g., organized by categories of information needs) during the collection phase. Scales and checklists are techniques for establishing orderliness.

Model I agencies collect more information about clients than do the other models, and Model III collects the least amount of information. It is surprising that barely more than half (53 percent) of the Model III agencies keep a record of the family composition, but perhaps, since these agencies are more committed to whole family participation, they feel less need for such records. Nearly all Model I agencies collect follow-up data, compared with about half of the other models. This may be because they work more intensively with their clients, and remain in touch through other services to which they have referred the families.

Most of the data are summarized and reported to several agencies, presumably funding sources.

7. Evaluation and Research. Less than 10 percent of all models reported that they did not conduct evaluation studies. However, more of the Model I agencies used outside contractors as evaluators: 35 percent for Model I, 22 percent for Model II, and 27 percent for Model III. This is consistent with the staffing of the agencies, since Model I has a lower staff education level, and some of these agencies may not be sufficiently knowledgeable about evaluation techniques.

Model I agencies are considerably less likely to participate in research: eight percent, compared to 19 percent of Model II agencies and 38 percent of Model III agencies. These data may be spurious, however, because participation in research was one of the variables used to identify Model III agencies.

B. Staff Characteristics

1. Size. Most of the agencies operate with relatively small family counseling staffs. Model II agencies tend to have the largest staffs, though there is a wide range among the models, and substantial overlap of the distributions: Model I agencies have the smallest staffs. It is difficult to describe the staffs in terms of numbers, because the ranges vary so much. For example, two Model II agencies reported paid full-time staffs of 100 or more. We suspect this may be a misinterpretation of the request for "number of staff providing family counseling services to clients" to include providers of other services as well. The median number of paid full-time staff is about four for Model I, six for Model II, and three for Model III. Model III is more likely to have part-time paid staff, and while Model I agencies reported two such staff at most, Models II and III had substantially more if they have them at all. Model I is more apt to make use of volunteers and interns, which is consistent with their smaller budgets.

2. Staff Qualifications. Less than half of the Model I agencies have advanced degrees, compared with 83 percent of the Model III agencies. For both Models II and III, the Master's is the modal degree.

Table IV-10 Counselors' Highest Degrees, by Model

	I		II		III	
	N	%	N	%	N	%
Less than BA	1	2	6	2	3	1
Bachelor's degree	27	52	108	34	42	16
Master's degree	21	40	175	55	176	69
Doctorate	3	6	24	8	30	12
Adv. professional degree	0	--	3	1	4	2

The fields in which the counselors have been trained are essentially the same for all three models, and are about equally represented in psychology, social work, and counseling. Nearly half of the Model III counselors have a license, certificate, or both, compared with 35 percent of the Model II counselors and 25 percent of the Model I counselors. Licenses ar more common in Model III agencies; certificates in Model I. These data are probably confounded, however, because states differ in whether licensure or certificates is the practice, and advanced degrees are often a requirement for one or both.

Although counselors in all models have about the same median number of years of experience in family counseling--a little over three years--Model I has more counselors with less than a year's experience: 20 percent, compared with 14 percent in Models II and III. About 8-10 percent of the counselors in all models are reported to have more than eight years of experience in family counseling, which may be inconsistent with the relatively short history of family counseling.

Table IV-11 Counselors' Experience with Family Counseling , by Model

Years	I		II		III	
	N	%	N	%	N	%
0-1	10	20	43	14	34	14
1-2	8	16	56	18	35	14
2-3	4	8	56	18	47	19
3-4	10	20	43	14	29	12
4-8	15	29	80	26	76	30
8-13	3	6	16	5	18	7
13	1	2	15	5	11	4

While about half of all model agencies reported having ongoing training in family counseling, more of the Model III agencies reported peer supervision of staff: 85 percent compared with 78 percent for Model I and 72 percent for Model II. More Model III agencies reported having a budget for training, and this budget is more likely to be an item in the agencies' budgets.

Counselors in charge of virtually all projects seem to be qualified people. In the one site we visited where none of the staff had a degree in a related field, a consultant with excellent credentials served as as trainer, supervisor, and co-counselor.

Two issues arise in considering "who is qualified" to perform certain types of services. The data reveal less formal training in family counseling for Model I service providers, yet given the needs of the client population, formal credentials may not be essential. Many Model I families reside in disadvantaged areas: survival and security take precedence over family problems. Addressing such priorities, combined with providing empathy and emotional support are viewed as the responsibilities of the Model I counselor. If "engagement" is a crucial element in a therapeutic relationship, and the Model I counselor can establish the rapport necessary to engage, then the counselor meets some standards for qualification.

The other side of the coin highlights the second issue--quality control of services. Those who are lobbying for state regulations that govern licensure might argue that minimum standards insure client protection through education and supervised clinical experience. If the current trend toward licensure gains momentum (six states now require a license to practice family therapy), Model I counselors may not be able to legitimately offer family counseling. But there appears to be no immediate threat.

What the tables don't show is the dedication of the counselors to their clients. Repeatedly during site visits we found counselors who spent many more hours than they were paid for to help clients with their problems. Model I and Model II agencies tended to have more clients in need of multiple services, and counselors often acted to put them in touch with appropriate sources of help. When the workload permitted, counselors followed up on clients who failed to show up for sessions, and exhibited extreme patience with the excuses offered. This is not to say that the counselors allow the clients to take advantage of them; rather, they try to sense what approach will work best for the long range growth of the client family.

C. Clients

1. Source of referral. In profiling the clients who receive a family intervention, we examined the source of referral to an agency or program, the presenting complaints which signal the need for help, and demographic data such as age, ethnicity, sex, and residential living arrangements.

The source of clients appear in the Table IV-12.

Table IV-12 Referral Source by Model: Percent of Clients

	I	II	III
Juvenile Court	24	23	22
Criminal Court	0	2	4
Family Court	0	3	2
Police Department	10	18	20
Probation Department	14	13	10
Parole Department	6	1	1
School	8	13	12
CMHC	1	2	1
Social Service/Welfare	4	6	3
Other Counseling Center	2	2	3
Self-referred	11	12	14
Other	21	6	8

The law enforcement agencies are the major suppliers of clients, representing approximately 55 percent of all clients to each of the three models. This isn't too startling, since our mandate specified a focus on the criminal justice system.

But there are some people knowledgeable about diversion, deinstitutionalization of status offenders, and decriminalization of juvenile offenders who might interpret these data as suggestive of law enforcement net-widening--enveloping clients into contact with officials whom the clients would normally never meet. In a recent study of the literature on the evaluation of diversion programs, Blomberg (1980) cites evidence from several evaluations that suggest little specificity in identifying the appropriate target population for diversion programs, those youth who would have entered the system prior to the establishment of diversion programs. This void leads to inclusion of many more youth in programs for which they previously would hve been ineligible, or in new programs designed to address wider populations. Lemert (1980) states that an unanticipated outcome of the trend toward diversion has been "its substantial preemption by police and probation departments." He also discusses the questionable relationship between police departments and some agencies because of the option for police to refer a youth to an agency and the agency's reliance on such sources for clients without whom no program would exist.

Our data are not complete enough to support or negate the idea of net-widening: we simply note the issue.

An interesting finding may be the range of non-criminal justice sources represented--the schools, social services/welfare bureaus, other counseling services, and "self" (walk-ins to an agency or suggestion to a parent or youth from one who received services). Educational institutions seem to be asking for help in dealing with troublesome youth, not just the truants (whom police have traditionally been asked to locate), but youths involved in other troublesome and disruptive activities. We learned that some schools have begun group counseling sessions for these youth and their families, the sessions often conducted by a family counseling specialist

from a community agency. There are attempts being made to identify "pre-delinquents" and provide some intervention before the youth becomes eligible for the law enforcement system. In our remarks on funding sources, we noted a shift from criminal justice monies for counseling activities to social service agencies--these expanded suppliers of clients may reflect that trend.

With respect to the "self-referred" clients, we note an hypothesis recently posed during an examination of gender-based discrimination in juvenile justice processing. The study looked at eight data sets on status offenders from six sites in the United States, and found little pattern of discrimination against males or females. However, the researchers observed a higher volume of female than male status offenders, and an overarrest rate for females who run away or are deemed incorrigible, and that these two offenses are parent-referred. The point is that these overrepresentations of females may be attributed to parents rather than the system, an hypothesis referred to as "parent-as-principal-actor-in-bias" (Teilmann & Landry, 1981). If parents are among the "self-referred," and if they seek assistance for their daughters more often than for their sons, then family counselors ought to be aware of this bias. It is clearly a topic for additional investigation.

2. Presenting complaints. Respondents checked (from a list of 10 for juveniles and 8 for adults) types of presenting complaints, indicating the most common. Those most frequently reported are shown below:

Table IV-13 Presenting Complaints: Juvenile I.P.

	I N=17		II N=129		III N=90	
	N	%	N	%	N	%
Incorrigible	3	17.64	44	34.11	33	36.67
Runaway	2	11.76	27	20.93	18	20.00
Truancy/School related	5	29.40	30	15.58	33	25.55
Shoplifting	2	11.76	11	.085	5	.056
Other (drug or alcohol abuse)	4	23.52	4	.031	5	.056

In the site visits, we learned that agencies exclude persons accused of violent crimes or who have been prosecuted. It seems that the family counseling projects treat nonprosecutorial youth, those whom the schools might refer to as "behavior problems," and those for whom a criminal career remains unestablished. The projects in our domain attempt to divert troubled youth from correctional institutions by helping them before they "go too far."

Among the Model II and Model III agencies, incorrigibility and runaway account for about 50 percent of the presenting complaints. We mentioned earlier in this section that there is a dearth of evidence regarding family

factors and various types of delinquent behavior. A recent study, however, examined adolescent behavior as the outcome of three phenomena--one was family influence--and gathered data that suggest "weak family integration had a definite positive effect on less serious types of norm violation," such as status offenses (Johnstone, 1978).

Perhaps agencies are including clients committing behaviors that reflect family problems, but not for the right reasons. Conditions established by sponsors, staff training, and limited resources were the reasons often cited as considerations in client selection. More attention should be given to the link between family situations and delinquent or status offense.

3. Demographic. Among the demographic variables, we learn that Models II and III tend to treat identified patients* between the ages of 14 and 17 (48.05 and 51.73 respectively account for between 80 and 100 percent of the cases). The second highest group for each agency is 13 years old or younger. Model I projects have a higher proportion of clients ranging from 18-25 years, but they represent less than 20 percent of the caseload. These agencies also treat about the same proportion of the youngest set ($\leq$ 13 years).

Whites are the most highly represented ethnic group among the clients: more than one-half of the Model II and Model III agencies report that between 80 and 100 percent of their clients are white. The converse is true among Model I agencies: less than one-half report the equivalent ratio. These agencies, usually community-based, service the Black community (64.29 agencies say Blacks account for between 10-99 percent, most less than 30 percent). All agencies also count Hispanics among their clients, usually representing less than 10 percent of the clients.

More than 60 percent of the Model I agencies report serving males between 60 and 100 percent of the time. The remainder of the agencies (average 44 percent) report a lower proportion of male clients for the equivalent range. Females appear to account for about half of the client population.

The living arrangements of the clients reveal a higher proportion of clients living with both natural parents among the Model II agencies (65 percent report this situation in more than 30 percent of the cases). The lowest representation appears in the Model I set (41.66 for the equivalent ratio) who also report the highest number of single parent clients. All models indicate a high volume of mixed families (remarriages). Only the Model IIIs treat clients families with adopted children in between 10 and 20 percent of the cases. Few clients come from foster homes.

---

* Identified patient (often called the I.P.) refers to the person who signaled the alert.

The implication of "who lives with whom" and delinquent behavior are unknown. Despite investigations on the general topic of families and delinquency, little progress has been made--certainly nothing on which to construct specific interventions. One review of the literature (Wilkinson, 1974) offers the idea that the rise and fall of the broken home theory vis à vis delinquency are closely related to the researchers' personal values on the importance of the "in-tact" traditional family. The significant changes in the composition of the family, such as single parent, mixed parents, and numerous other arrangements, demand the "family" be viewed in a new light.

D. Direct Services

1. Role of Family Counseling. In this section, we present the findings on the types of services family counseling agencies provide to their clients. At the outset of this study, we specified that for inclusion in the sample, family counseling must be the focus of the intervention, rather than a supplementary treatment for a specific, clearly identifiable problem. We quickly learned that the criterion represented a somewhat simplified view of reality. It became apparent that

- "family" held a variety of interpretations,
- the relationship of family counseling to other assistance was not universally perceived, even within an agency, and
- most family counseling agencies offered services in addition to the family intervention.

Of these, the first suggests some implications for the family counseling domain. A traditional or nuclear family no longer represents the norm--single parent families are growing in number, as are unions of one natural parent and one step-parent. Today's youth who experience household restructuring may spend a certain portion of time "living" in more than one household as a member of one or more families. Many agencies recognize this shift and include "significant others" in family counseling meetings. But universal or even systematic application of "family" is nonexistent. That counselors attempt to deal with "family systems" is commonly acknowledged, but treatment applications vary widely, as will be seen in the findings of direct services provided to clients.

We wanted some indication of how agencies viewed the family counseling function, so we asked the respondents to tell us approximately what proportion of the clients referred to or diverted from the criminal justice system received family counseling as

- the only form of treatment
- a primary component of treatment
- a secondary or supportive component of treatment

Table IV-14 summarizes the results:

Table IV-14 Percent of Cases Receiving Family Counseling

	I	II	III
As Only Treatment	35	35	48
*As Primary Treatment	43	54	69
As Secondary Treatment	52	44	23

* Includes "only treatment" cases

A chi-square of family counseling as the only treatment showed significance at the .02 level. Model III agencies report a higher volume of family counseling as the only activity. As a primary treatment, Model III agencies continue to rank higher. As a secondary activity, Model I agencies are significantly higher (.0001) in offering family counseling; we recognize that statistical significance was predictable because this was used as an indicator in sorting Model I agencies. The level of the significance confirms our judgment.

The continuum of family counseling reflected in the models--least to most--holds when viewed against this dimension. Further evidence exists when we examine what services, in addition to family counseling, these agencies provide.

The family counseling continuum used in the preliminary model construction following the site visits holds. We see further evidence when we examine what additional services these agencies provide.

2. Other Direct Services. The questionnaire listed 19 services, clustered in three groups (counseling, educational, and vocational services). Respondents indicated whether a particular service (if offered) was a primary or secondary component of treatment. Table IV-15 ranks the order of the outcomes for counseling services as a primary form of treatment.

One-on-one counseling with the identified patient ranks highest in all the agencies, but particularly high in Models I and II. Remember that these were intended to refer to other direct services in addition to "family counseling."* Model I appears to direct more attention toward the identified patient (usually a juvenile) than the other two Models. Model II shifts

* Conversations with counselors during the site visits revealed that individual and group counseling were often viewed as part of family counseling because the intervention treated the family system.

Table IV-15 Counseling as a Primary Treatment: High to Low Rank Order

	I			II	
	N	%		N	%
Individual/I.P.	12	85.71	Individual/I.P.	64	78.05
Group/I.P.	6	42.86	Parent Educ.	25	30.49
Parent Educ.	6	42.86	Individual/Family	23	28.05
Individual/Family	4	28.57	Group/I.P.	22	26.83
Group/Family	3	21.43	Couples	13	15.85
Other	3	21.43	Group/Family	11	13.41
Other	3	21.43	Group/Family	11	13.41
Couples	2	14.26	Other	8	.012

III		
	N	%
Individual/I.P.	35	54.69
Individual/Family	19	29.69
Group/I.P.	15	23.44
Couples	15	23.44
Parent Educ.	11	17.19
Group/Family	7	10.94
Other	1	.016

attention from the individual to the parents, then other family members. Model III also seems to work with the family as individuals.

The educational/vocational services included job and career counseling, tutoring, vocational training, job placement, and alternative schooling. As a primary service, both Model I and Model II agencies reported less than one percent activity. Some Model I agencies include job and career counseling (42.86 percent), tutoring (35.71 percent), and job placement (28.57 percent). As a secondary activity, the Model II and III agencies devote some attention to these services, most noticably in job and career counseling.

Other support services encompass a potpourri of activity--the findings scatter among a host of services such as youth advocacy, legal assistance, food/nutrition assistance, recreational programs and self-help groups. Again, the Model I agencies report the most attention as a primary treatment. Model II agencies (about 34 percent) report activity as youth advocates, as of course, do the Model I agencies (42.85 percent).

3. Session Characteristics. With respect to the sessions, we asked respondents to indicate how long a family counseling meeting usually lasted, approximately how many sessions a client-family attended, and about how long might a client remain on the active caseload. Family counseling sessions usually last 45-90 minutes in each of the three types of agencies. Some Model II agencies report longer sessions, lasting from one and one-half hours to three hours.

There is little or no evidence that length of session implies intensity or quality of treatment. But many counselors hold the view that the longer the session, the more intense the activity. A buildup occurs. In the site visits, Model III agencies conducted sessions of longer duration--often for a weekend or several hours during an evening. Among our models, III provides the most intense family therapy. Knowledge about the quality of time spent between a client and staff ought to be investigated.

The number of family counseling sessions held is shown in Table IV-16. The latter two groups showed significance at the .0333 and .0440 levels respectively.

Table IV-16 Number of Family Counseling Sessions: Average Percents

	Model		
	I	II	III
1 Session	4	7	9
2 Sessions	5	9	7
3-5 Sessions	30	35	28
6-12 Sessions	20	35	34
13 Sessions of More	41	14	22
	100	100	100

Some differences among the models apparently exist. Model I agencies spend a lot more time with their clients than the others, a finding consistent with one feature of Model I--the provision of multiple services which presumably requires much interaction between staff and client. Few clients spend a brief time with a Model I agency--these data might represent the dropout rate or an orientation with a client that leads to referral to another agency; similar explanations may be offered for many agencies which meet clients (or potential clients) infrequently.

Among the Model II agencies, 70 percent of the clients receive family counseling services for 3-12 sessions. These data correspond to crisis problem management--usually short-term counseling that addresses a specific problem. Some funding sources place restrictions on the maximum number of meetings between client and counselor, often not more than 12.

Model III agencies show that the highest number of sessions average between 6-12. These numbers are difficult to interpret because many Model III agencies conduct weekend or marathon sessions--we do not know how respondents counted these situations.

Table IV-17 shows how long an agency keeps a client on the active files.

Table IV-17 Length of Time on Books: Shown in Percents

	Model		
	I	II	III
Less than 1 Month	2	16	14
1-3 Months	29	33	39
4-6 Months	30	30	29
7-12 Months	20	19	13
More than 12 Months	19	2	5
	100	100	100

Without knowing agency record-keeping policy or minimum-maximum requirements regarding clients, or what happens in a session, we have little comment to make. Model I agencies remain consistent with earlier findings regarding their services--almost 40 percent of the clients are in the agency system for more than seven months, compared with about 20 percent for agencies within each of the other two Models.

4. Problems in delivering services. From a list of 14 commonly experienced difficulties in delivering family counseling services, we asked each respondent to rank the two greatest obstacles. The four most commonly reported "number one" problems were: (numbers in parentheses represent percent of total sample)

a. Failure to engage clients in family counseling because clients are too resistant to redefining the problem as a family problem--will only accept individual counseling (30.82)

b. Family members reject counseling altogether (16.35)

c. Failure to reach clients because the criminal justice system or school authorities do not always refer all the cases that would be appropriate (16.35)

d. Forced to turn away clients or see clients for too few sessions because of programmatic restrictions, personnel shortages or excessive caseloads (11.32)

There were some minor differences between models on the rank-order of these "top 4" problems. For example, Model I ranked the problem of "family members reject counseling altogether" higher than "failure to engage clients in family counseling..." and the reverse rank-order was found for Models II and III. This difference in rank suggests that clients served by Model I may be most difficult to engage in any form of counseling, family or otherwise. We've already commented on competing priorities in Model I: counseling is less important than basic needs. Model I also ranked the problem "forced to turn away clients because of programmatic restrictions, personnel shortages or excessive caseloads" somewhat higher than did the Model II and III agencies.

The two most frequently identified problems also appear among the "second greatest" problems:

a. Failure to engage clients in family counseling because clients are too resistant to redefining the problem as a family problem--will only accept individual counseling (18.18)

b. Family members reject counseling altogether (15.58)

A third problem also emerged:

c. Clients simply fail to show up for sessions (20.78)

All other problems were never identified by more than seven percent of the sample.

The reluctance of household members to view a situation as a family problem is a recurring theme heard from the practitioners--parents agree to attend sessions because they want to "help their troublesome offspring." The adults may reject the counseling when attention is directed toward them and issues they may view as private.

Clients who fail to appear for a session may have legitimate and fictitious reasons for staying away from the counselor. Lack of transportation (some counselors make home visits to compensate), forgetfulness, fear, are but a few examples.

The issue is that agencies do not know why clients fail to appear, so they do not take counter-measures to improve attendance. Agencies do not maintain a "tickler" file, so that clients are not reminded about a scheduled appointment or describe why attendance may be difficult. A tracking system may be in order.

The agencies also stated what proportion of client-families drop out or prematurely terminate treatment. Table IV-18 shows the findings.

Table IV-18 Proportion of Client Families Who Do Not Complete Treatment

	I		II		III		
Frequency	N	%	N	%	N	%	Marginals
0-29	6	49.99	44	63.77	33	57.90	60.14
30-99	7	50.01	25	36.23	24	42.10	39.86

The Model II agencies appear to lose fewer clients than the others--remember that these agencies offer short-term counseling, holding a significantly greater number of 3-5 sessions than Models I and III and may offer less threatening treatment. Model I agencies tend to complete treatment with a lower volume of client-families, but it may be difficult to determine when treatment ends.

E. Outcomes

During our visits to the sites, we interviewed a range of people associated with the project, as members of the staff or related in some other way, such as an outside evaluator or advisory board member. We met with project directors, family counselors, representatives of referral agencies (social service workers, court officials, police officers, school counselors), local government officials, and former project personnel--a total of 183 individuals. One category of questions we posed focused on project outcomes: where project made its greatest impact; areas in which limited successes were reached; achievement of stated objectives. In all cases, we asked for evidence used to measure attainment of the perceived outcomes. The evidence is scant and a direct attribution to the family intervention is debatable, at best. In the final chapter, we discuss some necessary requirements for conducting evaluations of family counseling activities within the criminal justice system.

Here we list the types of accomplishments reported by people in the field. The impacts fall into three general categories: the family; the criminal justice system; and the social service delivery system.

1. Families who receive counseling are viewed by counselors as:

   a. beginning to redefine their problems as family based rather than individually based;

   b. tending to shift from dysfunctional cycles generated by inability to handle stress toward increased capability to handle their own conflicts;

   c. staying together more often than those who did not receive therapy (e.g., a merged family considering dissolution of the newly formed unit because of their inability to cope with problems);

   d. increasing communication among family members, learning to resolve future crises;

   e. telling other families in need about their experiences and trying to inform them about the strategies learned in the sesssions;

   f. improving the quality of life for all family members;

   g. improving parenting skills, which leads to increased understanding of the relationships among family members; and

   h. improving family functioning.

2. Members of law enforcement agencies such as the police departments, courts, and probation departments observe that family counseling has:

a. offered a new perspective in assessing service delivery needs (e.g., there is a shift away from an orientation of punishing, out-of-home placements and from focusing upon the individual toward viewing the family in need. Tolerance has increased among many probation officers as they have come to view the individual's misbehavior as a family dysfunction);

b. helped to prevent premature labeling of youth in trouble (the effect of labeling is often a reduction in parents' willingness to support or help their adolescent or to consider the difficulties as family rather than individual ones);

c. offered an alternative to the traditional method of handling youth in trouble--away from the criminal justice system;

d. reduced juvenile court referrals of the first offenders, misdemeanant, and non-prosecutorial youth;

e. reduced court intakes and, consequently, reduced petitions and adjudication of the population identified above; and

f. reduced recidivism of juvenile offenders.

3. Social service workers report an influence of family counseling in:

a. decreasing out-of-home placement of troubled adolescents;

b. increasing the number of successful reentries into the home;

c. providing an alternative to the authoritarian treatment traditionally part of criminal justice interventions;

d. increasing awareness in community agencies about the benefits to be derived from a family systems approach to treatment;

e. making additional resources available to caseworkers as they serve their clients;

f. increasing the capability of the caseworker, who now looks beyond the individual toward the family as the focus of treatment and service delivery; and

g. allying agencies so that treatment originally focused on individuals can begin to include other family members.

We now attempt to draw together some ideas about the family counseling domain derived during this preliminary assessment.

V. Conclusions

This chapter summarizes our conclusions from three perspectives provided by the survey data from 160 agencies, personal visits to 18 sites, and our review of the literature. Our conclusions are organized as two topics. Within the first topic, we attempt to convey our overall impressions of the family counseling domain at the end of an 18-month investigation. Where appropriate, we offer examples of actual situations, as told to us by the practitioners with whom we spoke. Under the second topic, we present some gaps in knowledge--conditions or outcomes which have not been adequately assessed, but are important in understanding the family counseling process and its potential for success.

A. Overall Impressions

1. "Family" is a loosely applied term.

Practitioners who deliver family intervention services may work with several configurations, that can include an identified patient, single parent, two parents (natural or mixed), siblings, significant others (often a close friend of a single parent), and extended family members. Meetings may involve the counselor and one or more family members: participants at each session may vary. It isn't clear what "family counseling" means. Some counselors argue that if the entire family (household) does not meet together for a minimum number of sessions, real family intervention cannot occur. Others disagree, and treat unit(s) other than the entire family (usually referred to as subsystems) but label this as a family intervention. We found little consensus in the application, but general agreement that "family systems" were being treated.

2. Family counseling may be selected as the treatment because it happens to be available or because it is a current fad.

A police officer picked up a teenage youth who had run away from home and did not want to return. The officer was a new recruit and had just learned about a youth service agency in town which accepted young people any time of day or night. The runaway girl spent the next several days at the shelter, after being enrolled by the officer.

Agencies who offer family counseling as a primary intervention receive clients from a variety of sources. Sometimes family intervention may be the chosen treatment only because it is available and the act of referring relieves the original source from further responsibility. In the illustration above, a police officer took the youth to the agency because it was there, not because s/he believed the youth needed family counseling. Agencies may encourage such action by their easy accessibility, often on a 24-hour basis. In some localities, there are few competing options.

The important point is that most clients are not selected by a formal diagnostic procedure that indicates family counseling as the treatment of choice. Even if family counseling is deemed appropriate, little is known about what family factors influence a youth's troublesome or delinquent behavior, thereby increasing the difficulty of deciding what to "treat." One outcome of this is that counselors are asked to deal with a hodge-podge of events and family situations; this in turn, contributes to such things as agency backlog, high drop-out rates, and failure to engage clients.

3. Increasingly, youth serving agencies and institutions see family counseling as an option worth exploring.

An eleven-year-old girl in poor health missed six weeks of school. She did not want to return to school and remained home for several months. Finally, the school referred her for counseling. The mother and daughter had become very close during the young woman's confinement. The counselor strived to strengthen the parental relationship and encourage the mother to seek more emotional support from her husband. She clarified her parental role and insisted the daughter return to school. The daughter, relieved of taking care of her mother, resumed regular attendance at school.

We stated in the findings that family intervention seems best suited to juveniles. While our study was concentrated on applications within the criminal justice system, we learned in the course of our work that school referrals are increasing. Students whose behavior is disruptive or who are truant are deemed likely candidates for family counseling. School counselors and teachers seek earlier involvement for young people to prevent a later brush with the police and the courts. Some people believe that families may be more amenable to intervention when a juvenile is experiencing trouble in school than when he or she has been picked up for vandalism.

We also noted that some school districts ran their own counseling programs, funded by outside support (usually LEAA) aimed toward prevention rather than diversion.

4. Many agencies which offered family counseling under LEAA sponsorship are obtaining fiscal support from a variety of social service resources.

This shift indicates surprising stability for the field of family counseling. Many agencies received seed money from local and federal criminal justice sources. It was always intended that this would be a temporary source and that ultimately, local support would have to be developed. It now appears that many agencies achieved that goal. We encountered few projects that viewed the future as uncertain; agencies and/or projects within agencies caught the attention of local community mental health centers, state social service departments (occasionally Title XX money) or human resource units. Many once free-standing projects are now line items in someone's budget.

5. Family counseling has won a great deal of community support.

There are simply a lot of believers outside the family counseling agencies who credit them with a variety of successes--in reducing recidivism, lightening the load of the intake worker at Juvenile Court, providing an option to police officers who pick up a youth on the streets, and now have a place (other than court) to take this person. Whether or not evidence supports this notion, the idea is very strong. The basic idea (of the family as an important element in juvenile deviance) is appealing and the practitioners have been persuasive. The police, the courts, and the schools are generally supportive.

6. Convincing all household members to accept the troublesome behavior as a "family" matter is a major obstacle to treatment.

Mr. Jones insisted that the counselor only discuss his son's shoplifting. When the counseling shifted to his feelings or attitudes, he warned the counselor that it was his son, and not he, who has been arrested and that he would not return if the counselor persisted in trying to discuss disagreements between him and his wife.

Accepting the idea that a juvenile offense is a symptom of family dysfunction is a situation commonly faced by counselors. Any family member can play the game--a runaway female blamed her parents for being uptight, the parents described their daughter as disorderly, and one sibling reported that her father and sister fought all the time. Parents express surprise and often dismay when asked to consider the context of the event which precipitated the intervention. For some, acceptance leads to productive and useful sessions; for others, quick rejection of the idea and early termination. But acceptance is critical: youth who return to an unchanged family environment will not alter their own behavior.

7. The family counselors are very committed to the concept and responsive to client fears.

Counselors are sensitive to the difficulty many people feel about "receiving a service." For some, it carries a stigma associated with the underprivileged; for others, it's admitting an inability to take care of one's own family matters. We learned that attention is paid to making the family counseling experience a positive one--meeting people on their own turf, acknowledging cultural diversity within some families (may mean bilingual intervention or counselor from same culture treating the family), making the family feel good about themselves, meeting with the family members who appear for a session (even if for a few moments) so they will not feel time was wasted in meeting their obligations.

8. Family counseling seems to be the treatment of choice for youth who commit misdemeanors, non-violent crimes, and status offenders.

The case for directing this intervention toward these populations is debatable. Some would argue greater impact on among the more serious offenders. For now, energies focus on lesser offenders, and even shift to the preventive mode among early adolescents. In the chapter on findings, we mention the need for further investigation of this issue.

9. Only about one-half of a counselor's time is spent on service delivery.

Most of the counselors we interviewed reported that, in their view, a disporportionate amount of time was absorbed by paper work, case write-ups, phone calls, and other matters. The concern is the backlog of cases which can't be serviced because no time is available.

10. Agencies collect an enormous amount of data which are used in a limited fashion.

Several issues arise. Are data being collected unnecessarily, just for the record? Our observations reveal that most of the data are collected at intake (name, age, residence, offense, etc.), case notes are added to the file at the close of each session, but little time is saved for outcomes, especially observed by the counselor at the time of termination. Follow-up data are rarely found, because of the limited human and financial resources.

We feel the data are potentially useful, as discussed in the final chapter.

B. Knowledge Gaps

1. What are the effects of whole family involvement vs. family subsystem involvement?

Two conditions govern the number of family members who participate in the sessions. The first is the willingness of the counselor not to include the whole family in the treatment; the second is the lack of willingness by some members to be part of the treatment. We commented on the first condition in the previous section, "impressions." Here we address the second condition.

Obtaining the cooperation of all family members appears to be one of the greatest obstacles to family counseling. Not everyone shows up for the meeting; some member may be physically present but emotionally inaccessible. The missing link is often the adult male--a father, stepfather, or a mother's boyfriend. We heard anecdotes about adult males who came to the agency, but sat in an adjacent room (within hearing range) while their

family participated in the sessions. One counselor allowed the father to interrupt with remarks about the conversation, but never invited him to join; another counselor only permitted remarks from session members (he eventually joined). If a family member chooses not to attend the sessions, it is usually this person. We've heard counselors report other techniques for engaging this individual; some may pursue the intervention with the other family members because they believe it is better to treat the willing members rather than risk losing the whole family.

The effects need to be examined separately, with consideration of whether voluntary participation makes a difference in the treatment and subsequent results.

2. What is the relationship between the source of a family member's involvement in treatment and his or her commitment to the treatment?

The signal for help can be either internal (within the family) or external (a law enforcement officer, social service worker, or educator). Clients may be self-referred or they receive a strong suggestion from the judge that they agree to family counseling or suffer the consequences: and family counseling is clearly the lesser of two evils. Our data contain quite a volume of self-referrals in all models, and although we might expect these populations to be more committed to counseling, we do not know. On the other hand, court-mandated clients (occuring within few of our agencies) may take a very positive view toward the counseling, especially if it is the last chance before receiving a more drastic alternative. We spoke to some counselors who even preferred treating court-ordered families because of their high degree of cooperation.

3. What are the indicators of readiness to receive counseling? How can dropouts/failures be identified?

Terminations occur prematurely for several reasons--e.g., people stop coming to the meeting, they don't want to admit that a family problem exists. But apparently little is known about who stops coming and why--are these the people most in need? Agency resources are typically limited, allowing little or no time to pursue the dropouts. Many counselors prefer to work with the people who want help, rather than drain one's energies on those who reject. In a real-world context, there is a certain logic to that argument. What are the advantages/disadvantages of focusing on families which (a) are most in need, (b) are most receptive, or (c) are are most promising? Knowing more about the leavers may contribute to the success.

Counselors report that much of their energy is devoted to "engaging the clients." To some extent, perhaps counselors are getting people <u>in</u> a family ready for counseling <u>as</u> a family.

4. What effect does immediacy have on the intervention?

Sometimes a few days or weeks may pass between the "crisis" and the intake interview. Many agencies try to bridge the gap between initial contact and initiation of treatment with telephone calls, letters to the home, brochures, etc. Is it important to communicate with prospective clients who must wait their turn for counseling, and if so, what forms of contact are the most effective?

5. What benefits, if any, accrue to the siblings?

We raise two issues about the siblings of the identified patient--the first is the extent to which improved family functioning prevents them from committing minor offenses, or other troublesome behaviors. What happens within the family--their relationship to parent(s) and each other? The second is their personal role in the counseling, particularly among very young members. On some occasions, we heard reports about two-year-olds whose distracting behavior during sessions stimulated discussions about ways in which families cope with demands placed by one member on other members. From a different viewpoint, is it constructive to encourage the attendance of children who may or may not be aware of the dissonance in a household to witness the conflict and problem escalation often occuring in a family counseling meeting?

6. Should "success cases" be used to help in the counseling process?

We learned of a few occasions when parents who were helped by parent effectiveness training were asked to return and participate in the training of a new group of parents. The agency endorsed this strategy of peer support to reduce the heavy caseload on the counselors, to enhance the willingness of parents to receive help, and to reduce agency expenses (these are usually volunteers). What are the results of such practices? Are former (and successful) clients effective as trainers? The topic seems worthy of investigation.

7. What are the cost/benefits of varying kinds and amounts of training in regard to success rates of the intervention?

We see a wide range of training and experience within the family counseling field, from counselors with bachelor's degrees to Ph.Ds in psychology. We see less diversity among the overall strategies and techniques applied to the situations, particularly when the focus is on parenting skills, and communication among family members. Is there an ideal match between training and services?

8. What are the effects of (a) family functioning, (b) family structure, and (c) quality of family life on the behaviors that result in a young person's contact with the law enforcement system?

We discussed the absence of knowledge in these areas throughout the chapter on findings. We simply summarize by noting that the changing American family (in numerous ways) must be reexamined, especially if the family is to become the object for treatment of a variety of problems.

9. What are the long-term effects of family counseling?

We address this issue in greater detail in the final chapter on evaluability of the domain. The issue arises not only from the viewpoint of the families who experience the counseling but those who support the idea as a deterrent to new or repeated criminal behavior. Both intended and unintended outcomes must be examined.

VI. The Evaluablility of Family Counseling

This final chapter consists of three parts. The first, on using rationales, suggests ways in which conceptual models enhance both program development and evaluation. Next comes a section that summarizes evidence of treatment effects cited in evaluations of family counseling projects. The third part concludes by addressing the issue of evaluating family counseling activities within the criminal justice arena.

A. Using Rationales

In the first chapter, we mentioned that this preliminary assessment of the family counseling domain was a National Evaluation Program (NEP) Phase 1 study. One of the requirements for all Phase 1 assessments is the presentation of findings in the form of a flow diagram(s) or model(s). The overall purpose of this illustration was to depict points at which measurements could be taken to answer evaluation questions.

Models can also be viewed as a network of hypotheses, which makes explicit the dynamics of the cause-effect relationships being tested. Although models display the various stages of a program throughout the program's existence, the methodological focus is on the hypotheses that link events at one stage to those at the next. The usefulness of such a method is its value in determining which outcomes can be attributed to inputs. The models should describe programs (or specific projects) in terms of a linked set of activities that start with a commitment of resources, include key program activities, specify what interventions are being applied, and state the anticipated outcomes. The central feature of this methodology is that the intervention is not judged a success or failure based on a single measure of impact. The aim is to identify individual components that may require change or suggest additional emphases in modifying a program or conducting further evaluations.

Conceptual models are potentially very useful for the family counseling domain. Within the last 10 years, family intervention has been gaining acceptance among a diverse set of individuals--our immediate attention is on those within the criminal justice system who are seeking ways to promote the deinstitutionalization of status offenders and the diversion of youth whose violations would traditionally insure entry into the "system." Others focus on identifying and treating the pre-delinquent. Family counseling joins other treatment programs within the fields of crime and delinquency that have been the focus of evaluation efforts which attempt to record their success. These attempts have met with limited success.

Elliott (1980) suggests that the level of financial and human investment in evaluations of crime and delinquency programs ought to have produced a (1) body of knowledge about the effectiveness of certain intervention techniques and (2) some evidence about the validity of the theoretical models on which the interventions are based. His claim that we have learned very

little about these topics is based on the assertion that a major weakness in the evaluations has been an absence of comparability when investigating the intervention. Lack of comparability stems from a low number of replication studies coupled with researchers' preference for designing unique evaluations.* Comparability is also hampered because of the absence of models that make explicit the link between the events which constitute a program and to one or more anticipated outcomes.

Three major products of this study are the conceptual models that represent family counseling activity within the criminal justice system. These general models depict particular sets or classes of family counseling activity, a procedure that, as far as we know, has not only never been attempted within the field of family counseling, but has also seldom, if ever, been applied to a specific type of family intervention. Rationales that display the logic of specific kinds of strategies directed toward a family system which are then aimed at reducing or eliminating delinquent behavior did not exist. We do not fault the theoreticians or practitioners for not adopting what we consider to be a reasonable and necessary first step in program development and evaluation. It is not a common practice. Professions which are labeled as "helping" or focus on service delivery experience difficulty in being explicit about what they do and what they hope to accomplish. Family counseling is no exception, and one result of this is the tremendous ambiguity that characterizes the domain. Thousands of people offer help that is labeled "family counseling," and for every one you meet, a description of what they do contains something unique that sets it apart from other family counseling activities. In a sense, our models may reflect some of the abstruseness we noted about the domain. We do not claim to have produced the definitive set of models that represent the family counseling domain, but we do believe that these models hold value, as explained in the following ways.

1. <u>They contribute to the establishment of some order among widely diverse activities</u>. The continuum of family counseling activities illustrated in the models emphasizes similarities, thereby permitting an assembly of "like" projects.

2. <u>They are a necessary first step toward designing and conducting evaluations</u>. They provide a basis for discussions that lead to agreement of evaluation issues and the measures required to address the issues.

3. <u>They illustrate a way for individual projects to display their own objectives and outcomes</u>. The more general models can be used as a template from which specific projects can view their own procedures.

4. <u>They provide a first step toward comparability of a set of treatment strategies</u>. Like variable(s) may be examined across projects to permit aggregation of data.

---

* He also recognizes methodological limitations, as do others. We present the findings of our own examination of evaluation efforts in the next section of this chapter.

5. <u>They help recognize the existence of an array of success criteria</u>. By laying out the sequence of events, pinpointing the accomplishments necessary before proceeding from one event to another is facilitated. It also eliminates a reliance on the achievement of a global and often far reaching objective that might not occur for some time after the intervention.

6. <u>They contribute to identifying specific activities that may need to be modified or changed</u>. Again, the sequence of activities enables managers and evaluators to learn about why a particular piece of an intervention may or may not work, thereby honing in on where modifications are best suited. Information used for these purposes can be obtained early in the evaluation process.

A discussion of measures acceptable as proof of progress toward anticipated program outcomes comprises the final section of this report. Examples of measures and potential data sources appears as Appendix A. We now turn to a synthesis of the type of evidence currently used to assess family intervention.

B. Existing Evidence of Project Success

In this section, we address another aspect of evaluation by examining the current state of knowledge on family counseling treatment effectiveness. What evidence is used to determine success and what data contribute to knowledge about the treatment strategy?

To explore these questions, we relied on written documents as the object of our review, evaluation reports, journal articles, and NCJRS abstracts. We tapped several sources, including the literature on evaluation of family counseling treatments in crime and delinquency, agencies to which we made site visits, and those from the mail survey and telephone interviews who were kind enough to send copies of evaluations conducted of their activities. A total of 41 documents comprises this review: a list of the documents appears in the references.

The evidence derived from the materials is systematically keyed to the outcomes and impacts found in Boxes 32-47 of the Family Management Approach (Model II). We believed a presentation on one model was sufficient to impart a sense of evidence deemed appropriate to judge success of family counseling activities in the criminal justice network. It is worth noting that many of the outcomes and impacts in Model II also represent aims of Model I (Comprehensive Services Approach) and Model III (Family Restructuring Approach). Some of the differences in anticipated impacts among the three Models are linked to family functioning, where little evidence is found. We tended to focus on the criminal justice side.

Table VI-1 summarizes existing evidence for achievement of the following:

- Presenting crisis resolved

- Family stability restored
- Parental control reinforced/reestablished
- Resources for solving future problems established within family
- Family communication improved
- Parenting skills improved
- Identified client manifests acceptable behavior
- Juvenile client avoids premature labeling
- Improved quality of life for all family members
- Improved overall family functioning
- Reduced recidivism of identified client
- Diversion of identified client from juvenile justice system
- Reduced out-of-home placements
- Reduction of court referrals/intakes/petitions of first offenders and non-prosecutorial youth
- Reduction in number of youth picked up by police officers
- Introduced new perspectives in viewing service delivery needs of juvenile client and family as unit of treatment

There are two deviations in Table VI-1 from the Family Management Approach. First, evidence for "presenting crisis resolved" and "family stability restored" are jointly presented because evidence of the attainment of one outcome also represented attainment of the other. Second, evidence for "reduced recidivism of identified client" and "reduction of court referrals/intakes/petitions of first offenders and non-prosecutorial youth" are also combined because these two outcomes seem to basically represent the same phenomena.

Table VI-1 is organized into four major components. The first column identifies the outcome or impact. The second column presents a summary of the evidence regarding the particular outcome or impact: evidence may be "positive" (i.e., supporting achievement) or "negative" (i.e., not supporting achievement). Citing both positive and negative evidence provides a more complete, and perhaps more realistic, portrait of the existing evidence. In general, there seems to be more evidence of positive than negative outcome. However, several reasons may account for this, among them a tendency to fail to report negative findings.

The third column briefly describes some of the major features of a study's research design, so the reader can view the evidence in light of the chosen methods. We attempted to be complete (and fair) in reporting

design features, but we were often limited to what was contained in the document. In those cases where there was virtually no or only extremely minimal information, we attempted to contact the original authors of the report. However, in most cases, the authors were no longer with the corporations or agencies that conducted the research. Consequently, information gaps in the design features exist because of a lack of readily available information.

The final column provides the full reference for each document summarized in the table. To avoid having to repeat references, each is first presented in complete form and assigned a number. Additional citations are referred to by assigned number. Overall, the table reveals the following four outcomes/impacts had virtually no evidence at all: (1) parental control reinforced/reestablished; (2) resources for solving future problems established within the family; (3) parenting skills improved; and (4) juvenile client avoids premature labeling. These outcomes/impacts were not measured or assessed in any document we reviewed.

"Diversion of identified client from the juvenile justice system" and "reduced recidivism of the identified client" were the two impact areas with the greatest amount of evidence.

Our reporting of the evidence cited in numerous evaluation studies should not be interpreted as an endorsement of the methodology applied in each study or an acknowledgment that the findings demonstrate success of an intervention. We did not scientifically "evaluate the evaluations," although we have limited confidence in some of the findings. We, therefore, recommend caution when reading the claims. Observations about the assessments include:

1. absence of attribution that links the outcome to the intervention
2. lack of rigor in some of the research designs that results in misleading findings
3. sparse evidence upon which claims rest
4. inference of results rather than systematic reliance on evidence
5. global claims of effect
6. sample size was often very small and the proportion of the population it represented was not stated
7. minimum matching between comparisons, e.g., baseline data vs. end of treatment--using different populations
8. little attention given to long-term impact--follow-up data collected within few months of treatment, a few studies report effects after 12 months, only one at 18 months, and another after 24 months

9. stacking the deck both for and against family counseling through assignment of high risk youth to treatment and/or comparison groups

10. reliance on recividism as key indicator of project success; although this may be practical because of availability and low cost, there is little compelling evidence to suggest its validity as a measure of family intervention.

Table VI-1 follows. We then discuss how one might evaluate family counseling activities.

Table VI-1 Summary of Evaluation Evidence

OUTCOME/IMPACT	EVIDENCE SUMMARY: POSITIVE	EVIDENCE SUMMARY: NEGATIVE	DESIGN FEATURES	REFERENCE
Presenting Crisis Resolved (Box 32)	Majority of runaway youth in family counseling report, family conflict was alleviated.	---	Interviewed youth, parents, and counselors after treatment.	Fortune, A.E., & Reid, W.J. Images in looking glass--a study of a counseling center for runaways. 1972.(1)*
and Family Stability Restored (Box 33)	Youth report that participation in program eased family problems.	---	Pilot study of 16 participants (6 youth; 8 parents; 2 counselors). Used questionnaire both before and after treatment program.	Wilson, J.H. Henrico Court Alternatives Program--Pilot Series--Pre and Post Evaluation. 1975. (2)
	Decrease in conflict scores on the Moos Family Environment Scale and increase in cohesion scores on the Moos Family Environment Scale.	---	Pre and post-treatment assessment of 27 families. Only the cohesion scale was statistically significant although conflict was in the hypothesized direction.	Neale, L. and Dinsdale, M. Intensive family intervention: A delinquency diversion and prevention program. 1978. (3)
Parental Control Reinforced/ Reestablished (Box 34)	---	---	---	---
Resources for solving future problems established within family (Box 35)	---	---	---	---
Family Communications improved (Box 36)	Decrease in Family Incongruence Scores on the Moos Family Environment Scale (but not statistically significant).	---	Pre and post-treatment assessment of 27 families. Families completed the Moos Family Environment Scale. Incongruent score compares how family members agree on their perceptions of their family environment.	(3)
	Parents report improvement in "expressing yourself" and "accepting others."	Children report "no change" in "expressing yourself" and "accepting others."	Post-treatment assessment of 70 parents and 85 children who completed "Consumer Feedback" questionnaires.	(1)
	Family systems approach, when compared to the other conditions, produced significant improvement in clarity and precision of communication, clarity and precision of social reinforcement, and contingency contracting.	---	Pre and post-treatment assessment of 86 families randomly assigned to one of 4 groups: (1) no treatment (2) client-centered family counseling; (3) eclectic-dynamic counseling; (4) behaviorally-oriented family systems.	Klein, N.C., Parsons, B.V. & Alexander, J.F. Impact of family systems intervention on recidivism and sibling delinquency--A model of primary prevention and program evaluation. Journal of Consulting and Clinical Psychology. 1977. (4)
	Eighty-six percent of parents in phone survey and 80 percent of parents and youth at end of treatment report "a change in family communication."	---	Post-treatment assessment of 22 youth and 98 parents. Also included a telephone survey of seven parents.	Sutton, R.L. Program evaluation--intensive training for parents. 1978. (5)

* Each reference will be fully listed at first appearance and given a number. All remaining appearances of the reference will be by assigned number.

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
	Seventeen parents and youth report talking more and resolving problems by talking about them (but they didn't attribute these improvements to treatment).	Equal number of families report not being assisted by project as do those that say project helped them improve communication.	Pre-treatment, post-treatment and follow-up assessment of 43 families. Compared 488 youth case records with baseline data from pre-project years.	Fagan, J., Prather, A. & Waldorf, O. Evaluation of the comprehensive offender program effort (COPE) juvenile diversion demonstration program. 1978. (6)
Parenting Skills Improved (Box 37)	---	---	---	---
Identified client manifests acceptable behavior (Box 38)	Decrease in youth problem behavior scores after intervention. (Used Walker Problem Behavior Identification checklist and self-developed checklist.)	Average post-treatment, score for treatment group higher than standardized norms.	Pre-posttreatment assessment of 54 families; approximately half were in the treatment group and half in the comparison group (regular probation). Treatment and comparison families matched on youth's age, sex, and type and history of offense(s).	(5)
	In 3 of the 6 families, verbal abusiveness of child to parent decreased.	Curfew compliance, school attendance and performance of chores were not affected by treatment.	Study started out with 28 families but only 6 completed the treatment. Used behavioral self-report measures throughout and after treatment.	Weathers, L. & Liberman, R.P. Contingency contracting with families of delinquent adolescents. In C. Franks & G.T. Wilson (Eds.), Behavior theory and practice - Annual review (Vol. 4). 1976. (7)
	Decrease in youth's inappropriate behavior and social dysfunction.	---	Used case records and counselor post-treatment assessments. Also conducted interviews with community leaders.	Carter, G.W., Maloney, S. & Gilbert, G.R. Orange County, California - Evaluation progress report of the Alternative Routes project following 19 months of development and demonstration. 1973 (8)
	---	Twenty parents claimed that youth continued to give them the type of problem they had come to court to handle.	Staff evaluations of 69 youth. Follow-up telephone interviews with 69 youth and parents.	Lind, J. Hawaii family court - first circuit intensive intervention project evaluation. 1974. (9)
	Decrease in problem behaviors of youth.	---	Case studies with a time series design showing frequency of problem behaviors, interventions, and improvement of each problem behavior of 5 boys (represents 62 percent of total number of residents at home at one time).	Blum, D.J. Case studies in an evaluation of a community-based home for juvenile delinquents. 1975. (10)
	Increase in self-esteem and self-concept, decrease in alienation, and increase in positive attitudes toward law.	---	Pretreatment, posttreatment and follow-up assessment of 89 youths in treatment program. Follow-up data collected at 6 months and one year posttreatment.	Visionquest - Program evaluation report. 1978. (11)

OUTCOME/IMPACT	EVIDENCE SUMMARY: POSITIVE	EVIDENCE SUMMARY: NEGATIVE	DESIGN FEATURES	REFERENCE
	Increase in school performance and attendance.	---	Pre and posttreatment assessment of treatment and comparison group.	Project Intercept Final Report. 1974. (12)
	Eighty-two percent of counselor-set goals were attained at or better than the expected level of success.	---	Compared case records of 34 treatment families with baseline data from pre-project years. Also examined evidence of effectiveness on contracted goals using goal-attainment scaling procedures. Goals include reduction of problematic behaviors of youth. Also conducted structured posttreatment interviews with family members and examined recidivism data.	Wade, T.C., Morton, T.L., Lind, J.E. & Ferris, N.R. A family crisis intervention approach to diversion from the juvenile justice system. Juvenile Justice. 1977. (13)
	---	No increases in school enrollment, attendance or performance.	Pretreatment treatment and 3 month follow-up assessment.	(6)
Juvenile client avoids premature labeling (Box 39)	---	---	---	---
Improved quality of life for all family members (Box 40)	Parents report improvement in liking and accepting self, family living, understanding your child and improvement in marital relationship.	Youth report no change in liking and accepting self, family living, and understanding parents.	See description of (5)	(5)
Improved overall family functioning (Box 41)	Youth, parents and counselors report improvement in family life.	---	---	(2)
	70-85% of parents and youth report program had helped family.	10-14% of parents and youth report the program had not changed family.	See description of (5)	(5)
	---	Both program completers and program dropouts show improvement in family functioning.	Pre and posttreatment assessment of 29 families; 14 who completed treatment and 15 who dropped out of treatment in the first few days. Families took the Moos Family Environment Scale and records were examined for recidivism.	Druckman, J.M. A family-oriented policy and treatment program for female juvenile status offenders. Journal of Marriage and the Family. 1979. (14)
Reduced recidivism of identified client (Box 42)	56% of "successful" program youth had no offenses after discharge.	Of "successful" completers, 40% had posttreatment delinquent offenses.	Posttreatment assessment of 67 youth who "successfully" or "unsuccessfully" completed the treatment program during a 3-year interval. Examined juvenile court records for posttreatment convictions.	McGatha, E.A. Western Ohio Youth Center report on recidivism. 1980. (15)

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
	Project youth had recidivism of 15% as compared with 70 percent during pre-project period.	---	See description of (13)	(13)
	---	Higher rate of recidivism among program completers than program dropouts.	Examined juvenile court records at 6 months after treatment for post-treatment involvement.	(14)
	Eighty youth (22.9% of sample) were re-referred to Probation Department within 10 months. In 15 percent of the cases, the Probation Department filed a court petition. Eleven percent of sample had a petition filed for a delinquent violation.	---	Examined Probation Department master record files of 344 cases. Compared these data with baseline data from pre-project years.	Evaluation Report -- Sacramento County California Neighborhood Alternative Center. 1978. (16)
	Re-referrals for status offenders decreased 54	Re-referrals for criminal offenses increased slightly.	Examined 1979 Family Court record files for 910 cases.	Wertz, R.M. Jr. Deinstitutionalization of status offenders. 1979. (17)
	---	For status offender group, no difference between treatment and comparison groups. For delinquent offender groups, those in family counseling had higher recidivism than those in the comparison group.	Randomly assigned cases to probation officers who then had the option of assigning the case to family counseling (treatment group) or to traditional court services (comparison group). The probation officers constituted two groups: (1) those that frequently used the family counseling program and (2) those that seldom or never used the family counseling program. The researchers claim the method was faulty because officers placed higher risk cases into the family counseling program. Sample included clients charged with delinquent offenses (N = 328) and clients charged for status offenses (N = 199). Case Records for both offense groups were examined from time of referral to one year after referral.	Halfpenny, M., Burgess, C. & McCarthy, B. An evaluation of the family counseling program at intake. 1978. (18)
	Decrease in delinquent activity for both treatment and comparison groups but treatment group had less activity. Both groups continued to decrease activity at end of 1 year. By 2nd year, the treatment group had no change in delinquent activity but comparison group had a significant rise in recidivism.	---	Treatment and posttreatment assessment of 190 matched pairs of treatment and comparison groups. The comparison group received traditional probation services. Recidivism records were examined during treatment and 1 and 2 years after treatment.	Johnson, T.F. The results of family therapy with juvenile offenders. Juvenile Justice. 1977. (19)

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
	---	At 2-year follow-up, 27 cases in the treatment group had no further contact with the probation department. In the comparison group, 26 cases had no further probation contact. There were no significant differences between the groups.	Follow-up assessment of family counseling treatment group (N = 54 families) and a matched comparison group handled through court appearances. Treatment and comparison group matched in age, sex and offense of youth.	Austin, K.M. Thunder – An alternative to juvenile court appearance. California Youth Authority Quarterly. 1972. (20)
	There was 7% recidivism rate for treatment group as compared to a 20% recidivism rate for the control group.	---	Examined case records for 30 treatment and randomly selected comparison group. Comparison group received traditional probation and casework services.	Anderson, P.S., Roy, R.L., Howard, B.A., Dogoloff, M.L., Swarts, G., & Godfrey, T.A. Family crisis intervention program - Clark County Washington. 1979. (21)
	Treatment group had decrease in recidivism of 90 percent.	---	Pretreatment, treatment and posttreatment of 60 cases chosen from 440 cases of program participants since inception of program. Examined record of offenses.	Fairfax County Virginia -- Evaluation of the family systems program through December 1976. 1977. (22)
	Treatment group had 40% recidivism rate. Twenty-one percent of those that did recidivate were maintained in the community.	Likelihood of recidivism same for treatment and comparison group.	Compared family counseling treatment group with regular probation group. Used observation and interview data collected over a 2-year period.	Boisvert, M.J., Kenney, H.J. & Kvaraceus. Massachusetts Deinstitutionalization Data on one community-based answer. Juvenile Justice. 1976. (23)
	Sixty-seven percent of treatment group youth avoided subsequent contact with juvenile authorities.	Treatment group had slightly higher recidivism rate than comparison group. This is attributed to the higher proportion of recidivism related factors (prior record and type of offense) which researchers claim were disproportionately present in treatment group.	Fifty percent random sample of program cases constituted treatment group. Comparison group included similar offense cases given other informal dispositions by probation.	Sutton, L.P. CHIP – Children in need of supervision intervention project – a study of juvenile recidivism. 1978. (24)
	Treatment group had 53-58 percent fewer rearrests than comparison group.	---	Pre-posttreatment assessment of treatment and comparison group using psychological and educational measures.	(17)
	Recidivism rate for adult participants less than recidivism rate for persons on county probation.	No significant difference between adult participants and adults in other diversion programs. Juvenile clients had higher recidivism than comparison group.	Examined follow-up records of recidivism for selected number of adult and juvenile program participants. Compared recidivism rates of participants to those of other county diversion programs.	Weedman, C. Awakening Peace – End of the year evaluation report. 1974. (25)
	Twenty-three percent recidivism rate among first offenders and 45 percent recidivism rate among repeat offenders.	---	See description of (15)	(15)

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
	Court contacts for delinquent or status offenders declined from 47.6 percent to 39.8 percent during 8 months.	---	Compared data from 1974 with baseline data from 1976-1977 (1st year of program operation).	Clark County Washington Deinstitutionalization of status offenders evaluation report. 1978. (26)
	Treatment group had lower rearrest rate than comparison group.	---	Posttreatment and follow-up assessment of 30 matched pairs of treatment and comparison group youth.	Stratton, J.G. Effects of crisis intervention counselling on first or second time 601 or misdemeanor 602 juvenile offenders. 1974. (27)
	---	Sixty-two percent of treatment group and 55 percent of comparison group had further police contact.	Examined records of police contact 2 years after treatment for youth in family therapy treatment group or a comparison (no treatment) group.	Byles, J.A. Juvenile Services project — an experiment in delinquency control. Canadian Journal of Criminology. 1979. (28)
	More than four-fifths of participants had not run away again at time of follow-up.	---	See description of (1)	(1)
	Family systems treatment approach produced significant reduction in recidivism.	---	Assessed recidivism rates of identified delinquents 6-18 months following treatment. Eighty-six families randomly assigned to 3 comparative treatment groups and a no treatment control group.	(4)
	Family counseling treatment group had significantly less number of rearrests than the comparison group.	---	Sixty youth randomly assigned to family counseling treatment or to "traditional" treatment which included informal counseling, counseling with parents, filing of juvenile court petition or immediate detention. Post-treatment assessment of recidivism and conducted survey of parents and youth in the family counseling treatment group.	Stratton, J.G. Effects of crisis intervention counseling on predelinquent and misdemeanor juvenile offenders. Juvenile Justice. 1975. (29)
	Recidivism rate significantly declined during follow-up as compared to baseline rate.	Treatment group recidivism rate slightly lower (5%) than comparison group but the difference was not significant.	Obtained baseline comparisons from parents' report of youth's involvement with the juvenile justice system one year prior to entry in the treatment program. Recidivism rates obtained from parents' report and juvenile court records. Recidivism defined as number of recontacts with juvenile court one year following involvement in treatment program. Also, obtained matched comparison group from juvenile court records.	(3)

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
	Subsequent offenses for treatment group were slightly less serious than their initial offense. Subsequent offenses for comparison group were slightly more serious than their initial offense.	---	See description of (3)	(3)
	---	No significant difference between treatment and comparison group on self-reported recidivism. No change in type of offenses committed by treatment group.	Recidivism was assessed by 488 client self-reports during 3-month posttreatment period.	(6)
	Reduction in number of juveniles adjudicated delinquent or in need of supervision.	---	Examined case records of 70% of total caseload (216 cases). Comparisons made with 50% sample of 1973 (pre-project period) probation department records.	Project Crime (Community-Based Research to Improve Methods of Evaluation) Project Report 1 -- An evaluation of community-based prevention programs and innovative approaches to juvenile court services. 1976. (30)
	At follow-up, treatment group had less recidivism than comparison group, particularly for serious (non-status) offenses	---	Intakes randomly assigned to treatment or comparison group. There were 803 youth in treatment group, 558 youth in comparison group. Comparison group had traditional probation. There was a 12-month follow-up to assess recidivism.	Baron, R. & Feeney, F. Juvenile diversion through family counseling. 1976. (31)
Diversion of identified client from juvenile justice system (Box 43)	Project handled 977 referrals but filed only 36 petitions to court. Court processing lower for treatment than for comparison group. Treatment group had less probation supervision than comparison group.	---	Data available on 612 comparison group youth and 977 treatment group youth.	(31)
	Family counseling treatment group had significantly less youth on probation or in the juvenile detention facility at 6 months follow-up.	---	See description of (27)	(27)
	Comparison group spent longer average period of time on probation.	---	See description of (20)	(20)
	Decrease in number of status offenders on probation. Composition of probation case load changed to almost entirely male.	---	Examined 1979 probation department files for 910 cases.	(17)

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
	Admissions to juvenile hall reduced by 75 percent. Number of original court petitions reduced by 49 percent.	---	See description of (16)	(16)
	Substantial decrease in use and length of detention. Decrease in number of referrals after initial contact.	---	Compared 377 project cases with baseline data of 601 pre-project cases. Examined case records, administered questionnaires and conducted personal interviews.	Summerhays, J.J. Siskiyou County, California juvenile diversion project evaluation. 1974. (32)
	Police and schools state project enables them to divert youth from the juvenile justice system. Project reduces amount of time necessary to provide treatment as compared to traditional juvenile justice system case handling.	---	See description of (8)	(8)
	Significantly less family counseling cases were referred to the court. Seventeen percent of family counseling cases were referred as compared to 35 percent using the traditional probation system.	---	Forty-four families with a juvenile status offender randomly selected from one month's operation. Comparison group was composed of 54 families selected in the same month but one year earlier and before the family counseling project began. Examined number of cases referred to the court.	Beal, D. and Duckro, P. Family counseling as an alternative to legal action for the juvenile status offender. Journal of Marriage and Family Counseling. 1977. (33)
	Number of youths detained dropped from average of 56 a month to 37 a month.	---	See description of (26)	(26)
	Treatment group had 44 petitions filed while 93 were filed in the comparison group. This was a statistically significant difference.	---	See description of (20)	(20)
	Project group has 55% less filing of court petitions than pre-project group. Eighteen percent of pre-project cases were placed on probation whereas 9% of project cases were placed on probation. Reduction in average stay at Juvenile Hall from 4.3 to .81 days from pre-project to project cases.	---	Compared records of 491 baseline pre-project cases with 266 project cases.	Troyer, R.E. Preventing delinquency through diversion by short term family counseling -- Contra Costa County Department Central 601 Diversion project yearly report, July 1972-June 1973. 1973 (34)
	Number of petitions dropped from 27 to 4 during project year.	---	See description of (17)	(17)

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
	Significant reduction (75 percent) in number of petitions filed.	---	See description of (16)	(16)
	---	---	See description of (32)	(32)
	---	No difference between treatment and comparison groups on subsequent referrals.	Family counseling treatment group of 54 status offenders compared with no treatment comparison group of 70 status offenders.	Gruher, M. Family counseling and the status offender. Juvenile and Family Court Journal. 1979. (35)
	Family counseling group had significantly fewer cases of court referral than other groups.	---	Twenty-four families randomly assigned to one of 3 groups: (1) family counseling; (2) individual counseling; and (3) waiting list control group.	Shastak, D.A. Family versus individual-oriented behavior therapy as treatment approaches to juvenile delinquency. 1977. (36)
	Reduction in probation department caseload from target areas.	---	See description of (30)	(30)
	---	Law enforcement agencies did not divert youths from entering juvenile justice system. Number and rate of secure detention comparable to pre-project baseline data.	See description of (6)	(6)
Reduced Out-of-Home Placements (Box 44)	Reduction in number of commitments to state juvenile institutions.	---	See description of (30)	(30)
	Significant difference between treatment and comparison groups on number of days spent in detention in juvenile hall.	---	See description of (29)	(29)
	Most project cases were handled within the family. Number of court ordered foster home placements reduced from baseline period.	---	See description of (32)	(32)
	Long-term institutional placements decreased by 59 percent. Foster or group home placements decreased by 33 percent from baseline period.	---	See description of (16)	(16)
	Out-of-home placements reduced by 80 percent. Detentions reduced by 62 percent.	---	See description of (17)	(17)

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
	Youth in comparison group placed out-of-home more often than youth in the treatment group.	--	See description of (20)	(20)
	Seventy-one percent of the 41 youths who had previously been designated home placement "failures" were still at home after participating in program.	---	Examined records of 41 youths in residential treatment.	Rogert, A.J. & French, A.P. Successful short-term family therapy with incarcerated adolescents. Journal of Juvenile and Family Courts. 1978. (37)
	At follow-up, four-fifths of treatment youth were still at home.	---	See description of (1)	(1)

	Reduction in out-of-home placements for youth in treatment group.	---	Compared 75 youths in family therapy with 64 youths not given family therapy.	Michaels, K.W. & Green, R.H. Child welfare agency project — Therapy for families of status offenders. Child Welfare. 1979. (38)
	Forty-nine of 141 children at risk of placement avoided placement due to family involvement in therapy.	---	Interviewed referral workers to see whether they were considering placing the child out-of-home. If so, the child was considered "at risk" for placement. Examined records related to placement.	Cost Effectiveness Study. 1978. (39)
	Out of the 55 percent of the youth who completed the program, 78.4 percent returned home. Of those that did not complete the program, 34.1 percent returned home.	---	Examination of records of 93 youth; interviews with 10 staff members; interviews with 26 referral agents; and interviews with random sample of 10 client-families.	Lowy, M. Bill Wilson House Final Evaluation Report. 1979. (40)
	One third less of the project cases required out-of-home placement than the pre-project cases.	---	See description of (34)	(34)
	Eight youth in the treatment group were placed out of the home as compared to 22 youth in the comparison group. This was a statistically significant difference.	---	See description of (20)	(20)
Reduction in number of youths picked up by police officers (Box 46)	---	Sixty-two percent of treatment group and 55 percent of comparison group had police contact during follow-up.	See description of (28)	(28)
	Project reduced police contacts by 9 percent compared to pre-project comparison.	---	See description of (34)	(34)

EVIDENCE SUMMARY

OUTCOME/IMPACT	POSITIVE	NEGATIVE	DESIGN FEATURES	REFERENCE
Introduced new perspective in viewing service-delivery needs of juvenile client and family as unit of treatment (Box 47)	Interviews with community leaders indicate project was well received in target communities.	---	See description of (8)	(8)
	Personnel in county courts and social services report the project was a much needed and valuable counseling service.	---	Interviewed personnel in county courts and social services.	Manasse, S.E. Operation Prevention — Catholic Social Services: a project evaluation. 1976. (41)
	School counselors and other community referral agents report favorable impressions of the program.	Fifty percent of police officers interviewed were unable to form an opinion about the program.	See description of (40)	(40)
	Police report high satisfaction with the program.	---	Interviewed 11 police officers who refer to the program.	(16)

C. Evaluating the Domain

1. Current status. Consider the two questions:

   - How should a program of family counseling be evaluated?
   - How should a program of family counseling within the law enforcement/criminal justice system be evaluated?

It would seem that an adequate answer to the first question should be a part of an answer to the second. Stated another way, it would seem difficult to develop an adequate answer to the second question without at least knowing an answer to the first. If we did not know how to evaluate family counseling per se, it would not appear likely that we could evaluate it within some specified context. We make this rather obvious point because most of the evaluative efforts we have observed have been directed toward the second question and have given almost no attention to the first.

In our sample of projects, recidivism has been the most commonly employed outcome measure. The typical design is to take a convenient sample of juvenile offenders, expose them and their parents to a treatment labeled "family counseling" and then count the number in the sample who "recidivate" (commit some act which brings them into contact with the LE/CJ system) within some time period. The reduction (100% minus the per cent who recidivate) is then compared to that obtained for a sample of offenders not exposed to "family counseling." This design is not adequate to answer any important question about family counseling as a treatment--in or out of the LE/CJ system.* At the present time, the evaluability of family counseling projects is quite limited. This is not attributable to an absence of data; on the contrary, almost all of the necessary data are collected routinely by most projects. But there are very few evaluation plans, and none that we saw was comprehensive in scope. Evaluation is not seen as a routine, on-going activity; consequently, none of the projects organize their data for use in monitoring or longer-term evaluation. In the following section, we offer suggestions for the organization of data to facilitate both rapid feedback and more intensive forms of evaluation.

---

* It is possible to devise a question for which the design might produce an answer. Suppose that a juvenile judge learns that a neaby CMHC offers a service called "family counseling" and wants to know if this service might be a good thing for some of the juvenile offenders with whom he deals. Suppose further that of the next 100 offenders who reach his bench, he randomly assigns 50 to family counseling and 50 to probation-without-special treatment. Recidivism rates (over the next twelve months, perhaps) for these two groups could answer the question "Does family counseling as offered by this CMHC reduce recidivism over a one-year period of follow-up?" But we would learn nothing about the current or potential value of family counseling to the LE/CJ system.

2. Building evaluability in family counseling projects. Previous sections of the report have documented the extremely diverse set of treatments encompassed by the label "family counseling." The first requirement for evaluation is the availability of

   a. an explicit definition of the intended treatment.

      Projects know what they mean by "family counseling," but they seldom make it clear to anyone else. A definition is essential; it could take any of many forms, but should deal with: the essential rationale; the desired outcome (an operational definition of the functional family); presumed stages of teatment progress; participation requirements (whole family, all adults, etc.); average (expected) length of treatment; and any additional elements which serve to distinguish this particular variant of family counseling. The definition should hold for all clients of a given project.

Other requirements refer to the individual clients and must be organized on a case basis. The first is

   b. historical and demographic descriptors

      All projects collect the essential elements: sex and age of each member of the family, with residence and relationships; educational background; SES or proxy (occupational, for example); and significant events, including the "presenting complaint." The next two requirements are seldom found in project records:

   c. basis for assignment to family counseling

   d. estimated appropriateness of assignment

Some projects can be selective as to accepted clients; most cannot be. It is very important to know the basis for the assignment, even when it turns out to be "family was ordered by the court to receive family counseling." It is also desirable to obtain an early estimate--from a caseworker or counselor--of the family's readiness for the treatment. We believe that most counselors do, in fact, make an early judgment of this type but they do not record it. A very simple rating scale would be sufficient for the purpose. The next set of requirements is, to a considerable extent, available in the case files of client families. But digging them out would require a considerable effort and would almost certainly reveal a great deal of missing data. Since the counselor's notes on a counseling session are seldom recorded in a systematic fashion, important information will often be lost. We could imagine a single sheet of paper, requiring very little time of the counselor, to record

   e. place of meeting

   f. time (start-end)

g. attendance (check mark for each member present)

h. alliances manifest

i. expressions of affect (checklist for each member)

j. evidence of progress/regression/stagnation

k. status at close of meeting

l. targets for next meeting

Items i and j would be simplified if some standard categories were developed; in the absence of such, the evaluation would have to do the categorization post hoc. But it would still represent a significant gain over the present condition. The field would benefit greatly by widespread acceptance of some standard instrumentation. The most frequently mentioned dimensions of the family system (adaptability, cohesion, and communication) could be assessed by standardized instruments (see Olson, Bell, and Portner, 1978) but they seldom are. Existing instruments--and all instruments which will exist in the future--are imperfect. But they do provide a basis for looking across projects, and there are few bases for doing so at the present. Counselors talk about "stages" through which families (must?) pass, but they seldom record the stage; if this language is used in the definition (item a), it also should be used in item k. For the terminal meeting (even if the counselor does not know this at the time of the meeting, we need a record of

m. reason(s) for termination

n. status at termination (see item k)

o. counselor's prognosis.

If the above data were maintained in an organized way by a number of projects, we could aggregate similar projects (based on items a and b and for some questions, items c and/or d) and begin to answer such questions as:

- What per cent (of what kinds of clients) drop out of counseling prematurely?
- To what extent does family readiness for counseling influence success of the treatment?
- What are the gross relationships between expected and actual length of treatment, and each of these with success of treatment?
- What is the effect of whole-family versus part-family participation?
- Is there a relationship between the "presenting complaint" and success of treatment?...

and many others. We would, in general, be able to answer the first question raised in this section: "How should family counseling be evaluated?" We could then turn with some hope to the second question which concerns family counseling in the LE/CJ system. We will have less to say about these followup evaluations, since most would go beyond the authority and resources of the projects. In a follow-up study, we would certainly want measures of

p. recidivism: yes/no

q. recidivism: number and severity of offenses

r. offenses by other family members

s. school attendance and achievement: target and siblings (especially younger sibs)

We have not considered longer-term criteria of success of family counseling per se (marital stability, improved individual adjustment, etc.) since these are of but tangential relevance to our main concern. We also ignore cost/benefit studies, since there is a great deal of work to be accomplished before such work could be considered seriously.

References

(*References included in Table VI-1.)

Ackerman, N. The psychodynamics of family life. New York: Basic Books, 1958.

*Anderson, P.S., Roy, R.L., Howard, B.A., Dogoloff, M.L., Swarts, G., & Godfrey, T.A. Family crisis intervention program--Clark County, Washington. Arlington, VA: National Office for Social Responsibility, 1979.

*Association of Central Oklahoma Governments, Project C.R.I.M.E. (Community-Based Research to Improve Methods of Evaluation). Project report 1--An evaluation of a "community based prevention" and "innovative approaches to juvenile court services project." Oklahoma City, OK: Author, 1976.

*Austin, K.M., & Speidel, F.R. Thunder--in alternative to juvenile court appearance. California Youth Authority Quarterly, 1972, 24, 13-16.

*Baron, R., & Feeney, F. Juvenile diversion through family counseling. National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration. Washington, D.C.: U.S. Government Printing Office, 1976.

*Beal, D., & Duckro, P. Family counseling as an alternative to legal action for the juvenile status offender. Journal of Marriage and Family Counseling, 1977, 3, 77-81.

*Behavioral Research Associates. Visionquest--Program evaluation report. Tucson, AZ: Author, 1978. (NCJRS Document Reproduction Service No. 09900.00.056230) (Abstract)

Blomberg, T.G. Widening the net: an anomoly in the evaluation of diversion programs. In N. W. Klein & K. S. Teilmann. Handbook of criminal justice evaluation. Beverly Hills, CA: Sage Publications, 1980.

*Blum, D.J.S. Case studies in an evaluation of a community-based home for juvenile delinquents. Unpublished doctoral dissertation, University of Virginia, 1975. (NCJRS Document Reproduction Service No. 09900.00.049419) (Abstract)

*Bogert, A.J., & French, A.P. Successful short-term family therapy with incarcerated adolescents. Journal of Juvenile and Family Courts, 1978, 29, 3-8. (NCJRS Document Reproduction Service No. 09900.00.046078) (Abstract)

*Boisvert, M.J., Kenney, N.J., & Kvaraceus. Massachusetts deinstitutionalization data on one community-based answer. Juvenile Justice, 1976, 27, 35-40.

Boszormenyi-Nagi, I., & Framo, J.L. (Eds.). Intensive family therapy. New York: Harper and Row, 1965.

*Byles, J.A. Juvenile Services project--experiment in delinquency control. Canadian Journal of Criminology, 1979, 21, 155-165. (NCJRS Document Reproduction Service No. 09900.00.056572) (Abstract)

Carter, G.W., Maloney, S., & Gilbert, G.R. Orange County, California--Evaluation progress report of the Alternative Routes project following 19 months of development and demonstration. Los Angeles, CA: University of Southern California, 1973. (NCJRS Document Reproduction Service No. 09900.00.016704) (Abstract)

*Colorado Judicial Department. Project Intercept final report. Denver, CO: Author, 1974. (NCJRS Documentation Reproduction Service No. 09900.00.013780) (Abstract)

*Criminal Justice Research Foundation. Evaluation report--Sacramento County, California neighborhood alternative center. Sacramento, CA: Author, 1968.

*Department of Social Services, District XI Family Therapy Unit. Cost Effectiveness Study. Des Moines, IA: Author, 1978.

*Druckman, J.M. A family-oriented policy and treatment program for female juvenile status offenders. Journal of Marriage and the Family, 1979, 41, 627-636.

*Elliott, D.S. A repertoire of impact measures. In M.W. Klein & K.S. Teilman, (Eds.). Handbook of criminal justice evaluation. Beverly Hills, CA: Sage Publications, 1980.

*Fagan, J., Prather, A., & Waldorf, O. Evaluation of the comprehensive offender proeram effort (COPE) juvenile diversion demonstration program. San Francisco, CA: Urban and Rural Systems Associates, 1978.

*Fortune, A.E., & Reid, W.J. Images in looking glass--A study of a counseling center for runaways. Chicago, IL: Travelers Aid Society, 1972.

*Gruher, M. Family counseling and the status offender. Juvenile and Family Court Journal, 1979, 30, 23-27. (NCJRS Document Reproduction Service No. 09900.00.056349) (Abstract)

Haley, J. Uncommon therapy. New York: W. W. Norton, 1973.

*Halfpenny, M., Burgess, C., & McCarthy, B. An evaluation of the family counseling program at intake. Tucson, AZ: Maricopa County Juvenile Center, August 1978.

*Institute of Policy Analysis. Clark County, Washington deinstitutionalization of status offenders evaluation report. Eugene, OR: Author, 1978.

Jackson, D. Therapy, communication, and change. Palo Alto, CA: Science and Behavior Books, 1968.

*Johnson, T.F. The results of family therapy with juvenile offenders. Juvenile Justice, 1977, 28, 29-33.

Johnstone, J.W.C. Social class, social areas and delinquency. Sociology and Social Research, 1978, 63, 49-72.

Johnstone, J.W.C. Juvenile delinquency and the family: A contextual interpretation. Youth and Society, 1978, 9, 299-313.

*Klein, N.C., Parsons, B.V., & Alexander, J.F. Impact of family systems intervention on recidivism and sibling delinquency--model of primary prevention and program evaluation. Journal of Consulting and Clinical Psychology, 1977, 45, 469-474.

Lemert, E.M. Diversion in juvenile justice: What hath been wrought. Journal of Research in Crime and Delinquency, 1981, 18(1), 34-45.

*Lind, J. Hawaii family court--first circuit intensive intervention project evaluation. Hilo, HI: Hawaii Family Court, 1974. (NCJRS Document Reproduction Service No. 09900.00.026164) (Abstract)

*Lowy, M. Bill Wilson House Final Evaluation Report. Santa Clara, CA: Santa Clara County Justice Division, 1979.

*Manasse, S.C. Operation Prevention--Catholic Social Services: A project evaluation. Wilmington, DE: Delaware Agency to Reduce Crime, 1976. (NCJRS Document Reproduction Service No. 09900.00.038943) (Abstract)

*McGatha, E.A. Western Ohio Youth Center report on recidivism. Ohio: Western Ohio Youth Center, May 1980.

*Michaels, K.W., & Green, R.H. Child welfare agency project--therapy for families of status offenders. Child Welfare, 1979, 58, 216-220.

Minuchin, S. Families and family therapy. Cambridge, Mass.: Harvard University Press, 1974.

*Neale, L., & Dinsdale, M. Intensive family intervention: A delinquency diversion and prevention program. Portland, OR: The Morrison Center for Youth and Family Service, April 1978.

Parsons, B.V., & Alexander, J.F. Short-term outcome study. Journal of Consulting and Clinical Psychology, 1973, 41, 195-201.

Satir, V. Conjoint family therapy. Palo Alto, CS.: Science and Behavior Books, 1964.

Satir, V. FAMILIES: Growing in a Relative Way. Washington Post, March 1981.

*Shostak, D.A. Family versus individual-oriented behavior therapy as treatment approaches to juvenile delinquency. Unpublished doctoral dissertation, University of Virginia, 1977. (NCJRS Document Reproduction Service No. 09900.00.045394) (Abstract)

*Stratton, J.G. Effects of crisis intervention counseling on first or secondtime 601 or misdemeanor 602 juvenile offenders. Unpublished doctoral dissertation, University of Southern California, 1974. (NCJRS Document Reproduction Service No. 09900.00.051022) (Abstract)

*Stratton, J.C. Effects of crisis intervention counseling on predelinquent and misdemeanor juvenile offenders. Juvenile Justice, 1975, 26, 7-18. (NCJRS Document Reproduction Service No. 09900.00.030702) (Abstract)

Stuart, R. Behavioral contracting within the families of delinquents. Journal of Behaviour Therapy and Experimental Psychiatry, 1971, 2, 1-11.

*Summerhays, J.J. Siskiyou County, California juvenile diversion project evaluation. Yreka, CA: Siskiyou County Probation Department, 1974.

*Sutton, L.P. CHIP--Children in need of supervision intervention project--A study of juvenile recidivism. Albuquerque, NM: Albuquerque Second Judicial District, 1978. (NCJRS Document Reproduction Service No. 09900.00.046421) (Abstract)

*Sutton, R.L. Program evaluation--Intensive training for parents. Las Vegas, NV: Clark County Juvenile Court Services, September 1978.

Teilmann, K. S., & Landry, P. H., Jr. Gender bias in juvenile justice. Journal of Research in Crime and Delinquency, 1981, 18, 47-80.

*Troyer, R.E. Preventing delinquency through diversion bv short term family counsleing--Contra Costa County Department Central 601 Diversion project yearly report, July 1972-June 1973. Martinez, CA: Contra Costa County Probation Department, 1973.

*Wade, T.C., Morton, T.L., Lind, J.E. & Ferris, N.R. A family crisis intervention approach to diversion from the juvenile justice system. Juvenile Justice, 1977, 28, 43-51.

*Weathers, L., & Liberman, R.P. Contingency contracting with families of delinquent adolescents. In C. Franks & G.T. Wilson (Eds.), Behavior Theory and practice--Annual review (Vol. 4). New York: Brunner/Mazel, 1976.

Weintraub, J.F. The delivery of services to families of prisoners. Federal Probation, 1979, 40, 28-31.

*Weedman, C. Awakening Peace--End of the year evaluation report. La Jolla, CA: La Jolla Human Research Laboratory, 1974. (NCJRS Document Reproduction Service No. 09900.00.016701) (Abstract)

*Wertz, R.M., Jr. Deinstitutionalization of status offenders. East Baton Rouge, LA: East Baton Rouge Family Court, December 1979.

Whitaker, C. The hindrance of theory in clinical work. In P.S. Guerin, (Ed.), Family rherapy. New York: Gardner Press, 1976.

Wholey, J. Evaluation: Promise and performance. Washington, D.C.: The Urban Institute, 1979.

Wilkinson, K. The broken family and juvenile delinquency: Scientific explanations or ideology? Social Problems, 1974, 21, 726-739.

*Wilson, J.M. Henrico Virginia Court Alternative Program--Pilot series--pre and post evaluation. Richmond, VA: Virginia Council on Narcotics and Drug Abuse Control, 1975. (NCJRS Document Reproduction Service No. 09900.00.019498) (Abstract)

Appendix A:

Model III: Suggested Indicators and Data Sources

MODEL III FAMILY RESTRUCTURING APPROACH

ELEMENT*	POSSIBLE MEASURES	DATA SOURCES
Inputs		
1	Amount of funds applied for and received by program/agency	Grant awards, agency financial records
	Date funds received	Grant awards, agency financial records
	Number of staff hired	Agency records
	Characteristics of staff hired	Application forms
	Physical characteristics of facility and location	Observation, grant applications
	Agreements established for staff	Staff Contracts
2	Number and kind of brochures, pamphlets about the program	Public relations materials
	Number and kind of presentations about the program	Agency records
	Number and kind of people attending presentation	Observation, staff reports
	Number and kind of news briefs/announcements about the program	Self-reports by staff
	Existence of mailing	Agency
	Number and kind of people sent information about the program	Scrap books Library
3	Number and kind of training program(s)	Manuals
	Attendance of staff at training program(s)	
	Number of percent of staff trained	
4	Number of referral agencies contacted (formally and/or informally)	Agency records
	Existence of working agreements between program and referral agencies	Agency records
	Number of kind of mechanisms in place to link with referral sources	Staff interviews, interviews with network members
Immediate Outcomes		
5	Number of staff trained	Agency records
	Perception of adequacy of facilities	Observation checklist
	Number of formal and/or informal contacts with referral sources	Records; interviews
	Number of materials disseminated by audience types	Agency Records
Process		
6	Number and percent of referral received from: courts police probation schools social services self	Agency records, referral source records, summary reports, interviews

* Numbers in this column correspond to numbers in each box of the Model III rationale.

ELEMENT	POSSIBLE MEASURES	DATA SOURCES
7	Number and percent of clients receiving: interview psychological assessment treatment contract orientation to treatment program data collection Number and percent of family client receiving: interview psychological assessment treatment contract orientation to treatment program data collection Number and percent of therapist contact with referral person	Agency records, staff interviews, observation, client interviews, standardized measures Case notes Client file
8	Number and percent of clients and/or families accepted for treatment program	Intake files Staff interview Summary reports
9	Number and percent of clients and/or families not accepted for treatment program	
10	Number and percent of clients and/or families referred to another service provider Number and percent of clients and/or families referred to another service provider by type of provider Number and percent of clients and/or families referred back to original referral source Number and percent of clients and/or families referred back to original referral source by type of referral source Number and percent of clients and/or families who drop out of the referral process Number and percent of clients and/or families who drop out of the referral process by reason for dropout	Records listed above Records of referral source Placement records Summary reports Case files Counselor interview
11	Extent to which client and/or family perceives therapist as helper and leader Extent to which therapist perceives him/her self as being helper and leader Extent to which client and/or family feels supported by therapist and trusting of therapist Extent to which therapist feels she/he is supportive and trustworthy towards the client and/or family Extent to which family feels challenged Extent to which therapist thinks she/he has challenged the family Amount of information gathered about presenting problem and family history Percent of time therapist spends gathering information Extent to which the family redefines presenting problem Extent to which the therapist redefines presenting problem Percent of time therapist spends redefining presenting problem Extent to which therapist observes family interaction and dynamics Nature of observational method Percent of time therapist spends observing family interaction and dynamics	Standardized measures Client questionnaires Client interviews Observations

ELEMENT	POSSIBLE MEASURES	DATA SOURCES
11 cont'd.	Extent to which family describes problems Percent of time family spends describing problems Extent to which family members describe family Percent of time family members spend describing family Extent to which family members identify treatment goals Amount of time family spends exploring treatment goals Extent to which family members establish commitment to enter therapy Existence of a formal or informal commitment (e.g. contract)	
12	Number and percent of therapy sessions videotaped Number and percent of therapy sessions observed behind a one-way mirror Number of professionals who observe the sessions Number and percent of times the referral person participates in the therapy session	Library: Agency files Case files Summary reports Referral source records
13	Extent to which therapist diagnoses family functioning Existence of a formal written diagnosis Amount of time therapist spends formulating diagnosis	Case files Therapist interviews Therapist completes checklist/ questionnaire Summary reports Outside consultant reports/interview Observations
14	Extent to which therapist develops hypotheses about family dynamics Amount of time therapist spends developing hypotheses	
15	Extent to which therapist develops treatment goals Existence of formally written treatment goals Number of goals developed	
16	Extent to which family perceives an escalation of stress Extent to which therapist perceives an escalation of stress Extent to which areas of disagreement among family members are highlighted Extent to which usual communication flows are altered Extent to which therapist forms coalitions with family members Extent to which problem is relabeled as family system problem (by therapist and client/family members) Extent to which therapist models clear communication and affect Extent to which family rules are explored and challenged Extent to which family roles, positions and coalitions are examined and challenged Number of percent of sessions focusing on the marital relationship Number and percent of sessions focusing on the sibling relationship	+ Client(s) interviews Client(s) completes questionnaire Clients as sources may be interviewed individually or as a group

ELEMENT	POSSIBLE MEASURES	DATA SOURCES
18	Number of times therapist reviews and discusses case with colleagues/supervisor	Therapist interviews Consultant observations Supervisor report forms Case files
19	Number of times therapist discusses case with referral person	Therapist interviews Interviews with referral
20	Existence of review process Number and percent of goals reviewed Number and percent of goals revised	Case files Therapist records
21 22	Number and percent of treatment goals not accomplished Number and percent of treatment goals accomplished	Case files Summary reports Therapist interview
23	Extent to which goal accomplishments are reviewed Number of unmet treatment needs identified Extent to which relapses are predicted and number of ways to avoid relapses identified Number of referrals to other service providers Extent to which data on client and family is collected	
24	Extent to which family members take responsibility for their own action and how their behavior affects others	Family interviews, as group and individually Follow-up phone survey or questionnaire Case files: recontacts Observation Extended family interviews "Significant other" interviews
25	Extent to which family communication and problem-solving improved	
26	Extent to which appropriate roles for family members developed	
27	Extent to which parental subsystem is strengthened	
28	Extent to which marital relationship is strengthened Number of decisions to divorce	
29	Extent to which family members report the presenting problem has been eliminated, redefined or reframed Extent to which the therapist reports the presenting problem has been eliminated, redefined or reframed	Family interviews as group or individually Observation Therapist interview Observation Case files
30	Extent to which therapist reports that inappropriate subsystems broken	

ELEMENT	POSSIBLE MEASURES	DATA SOURCES
31	Extent to which family members report on-going personal and family adjustment Extent to which therapist reports on-going personal and family adjustment	Family sources identified earlier Therapist sources mentioned earlier
32	Extent to which individual intrapsychic changes in family member(s) occur	Family sources Therapist sources Observation
Longer-Term Impacts		
33	Number and percent of institutional placements Number and perdent of foster home placements	Institution and Placement records Summary report
34	Number and percent of youth returning to court Number and percent of new arrests for criminal charges Number and percent of court petitions filed Number and percent of formal court hearings Number and percent of re-referrals to probation/parole Number and percent of readmissions to Juvenile Hall	Court records Police records
35	Number and percent of court petitions filed for other family members Number and percent of arrests of other family members	
36	Extent to which therapist reports an alteration in family system (evidence of changes in roles, rules, boundaries, coalitions) Extent to which family member(s) report an alteration in family system (evidence of changes in roles, rules, boundaries, coalitions)	Therapist interview checklist Case files Family interview Standardized instruments Observation
37	Extent to which each family member reports improvement in their quality of life	Family interview Standardized scales; other instruments Observation
38	Extent to what aspects of family functioning (support, regulation, nurturance, socialization) are improved	Family interviews Standardized instruments Observation Case files Therapist interviews
39	Number of relevant persons who view family therapy as good treatment for criminal justice clients Number and percent of increase in referrals to family therapy for criminal justice clients	Community interviews, questionnaire Referral sources Records: recommendations by friends, etc.

ELEMENT	POSSIBLE MEASURES	DATA SOURCES
40	Number of client/family members who develop new non-criminal justice related problems	Agency records School counselors: records
41	Extent to which future generations in the family develop criminal-justice related problems and in family functioning	Long-term follow-up interviews, questionnaires, agency and court records
42	Number of funds available for family therapy programs and training Nature of funds available for family therapy programs and training Number of available funds by nature of funds	Sponsor funding patterns--record of awards Agencies in existence; workshops offered

Appendix B:

Mail Survey Questionnaire

Keytaping Column

1-8

9-11,12

13-14

This survey is conducted under LEAA Grant 79-NI-AX-0102

ID No. ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋

NEP PHASE I ASSESSMENT: Family Counseling

● AGENCY IDENTIFICATION

A. Agency Name _____

Address _____

Director _____ **Telephone No.** _____

B. In your own words, please describe the nature of your agency and the services you provide (key goals and how you reach them).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

THIS SURVEY IS LIMITED TO AGENCIES THAT PROVIDE FAMILY COUNSELING TO CLIENTS WHO ARE DIVERTED FROM OR REFERRED BY THE CRIMINAL JUSTICE SYSTEM AS PART OF THEIR SERVICES.

C. Does your agency provide family counseling to such clients? ☐ Yes ☐ No

If your answer is "No", you need not complete the questionnaire. Please return the form in the enclosed envelope.

If your answer is "Yes," indicate the approximate number of client families who are diverted from or referred by the criminal justice system. *

⌊_⌋⌊_⌋⌊_⌋ per _____

Approximately what proportion of your total number of clients does this category represent? ⌊_⌋⌊_⌋

Please complete the remaining items in this questionnaire. We appreciate your willingness to participate in this nation-wide survey.

* Please indicate whether your estimate is based on monthly, quarterly, or annual records.

● AGENCY CHARACTERISTICS

15–18 **1. In what year did your agency begin?** _____

2. What are the sources of funding for your current fiscal year?

	Name of Source	Amount of Funds
19–29		
30–40		
41–51		
52–62		
63–73		

74 **3. Has your agency ever received LEAA funding in prior years?** ☐ Yes ☐ No

75–86 **If yes, when** _____ **and for what amount?** _____

87–98 _____ _____

99–110 _____ _____

111–122 _____ _____

4. Characterize the area your agency serves:

123, 124

a. Population

- ☐ (1) less than 2,500
- ☐ (2) 2,500–10,000
- ☐ (3) 11,000–25,000
- ☐ (4) 26,000–70,000
- ☐ (5) 71,000–100,000

b. Geographic Unit

- ☐ (1) central city
- ☐ (2) metropolitan city
- ☐ (3) suburban
- ☐ (4) rural area
- ☐ (8) other (specify): _____

5. How many other agencies in your immediate service area offer family counseling for client-families diverted from or referred by the criminal justice system?

125 ☐ none ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or more ☐ don't know

6. Is there any legislation (federal, state, or local) that either created or influenced your services?

126 ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

_____

7. Are there any other influences (political situation, interests of local judicial officers, etc.) that affect your services?

127 ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

_____

● CHOOSING THE FRAME OF REFERENCE

We are interested in the nature and extent of family counseling services you provide. Some programs and/or agencies:

- provide ***only*** family counseling services; or
- provide family counseling as ***one of many*** services.

If family counseling is the ***only*** service offered by your agency, then frame of reference is not an issue. But if family counseling is ***one of many*** services offered, then you would complete the questionnaire from

- an **agency** frame of reference, if family counseling is fully integrated with other activities, sharing staff, funds and facilities (e.g., a shelter facility)
- a **program** frame of reference, if family counseling is a distinct organizational entity, with its own budget and staff (e.g., a diversion unit).

We recognize that many agencies will not be described by either of these "pure cases." The family counseling staff may be a distinct unit, but there may be no separable budget, for example. Choose the frame of reference which best fits your situation, and use that choice as the basis for answering the questions which follow.

128 **8. Please indicate whether you will be describing a "program" or an "agency."** _____

FOR THE REMAINDER OF THIS QUESTIONNAIRE, PLEASE ANSWER FROM THIS FRAME OF REFERENCE UNLESS ASKED TO DO OTHERWISE.

9. How would you best characterize your program/agency? (Select no more than one in each of the three sets).

129 a. BROAD-BASED MENTAL HEALTH

- (1) ☐ Family and Children's Service
- (2) ☐ Community Mental Health Center
- (3) ☐ Counseling Center
- (4) ☐ Community Program
- (5) ☐ Family Counseling Center
- (6) ☐ Child Guidance Center
- (7) ☐ Mental Institution
- (8) ☐ Individual Clinician
- (9) ☐ Other (specify): _____

130 b. YOUTH-ORIENTED

- (1) ☐ Status Offender Diversion Program
- (2) ☐ Youth Service Bureau
- (3) ☐ YMCA
- (4) ☐ Community Youth Program
- (5) ☐ Group Home
- (6) ☐ Crisis/Runaway Shelter
- (7) ☐ Other (specify): _____

131 c. DIRECT CRIMINAL JUSTICE

- (1) ☐ Police Department
- (2) ☐ Probation Department
- (3) ☐ Juvenile Court
- (4) ☐ Family Court
- (5) ☐ Criminal Court
- (6) ☐ Correctional Institution
- (7) ☐ Other (specify): _____

132 d. Other (Please decribe): _____

_____

_____

_____

133 If your program/agency has a residential treatment component, please answer questions 10 through 13. If you do ***not*** have a residential treatment component, place a check ( ) here and go on to the next section (Documentation).

134 **10. What is the average length of stay in the residence?**

- ☐ (1) one day
- ☐ (2) 1–3 days
- ☐ (3) 4–7 days
- ☐ (4) 8–14 days
- ☐ (5) 15–30 days
- ☐ (6) 1–2 months
- ☐ (7) 3–6 months
- ☐ (8) 6 months–1 year
- ☐ (9) over 1 year

135 **11. Does the residence house:**

- ☐ (1) adults only
- ☐ (2) both adults and juveniles
- ☐ (3) juveniles only
- ☐ (8) other (please specify) _____

136 **12. Is the residence coeducational?**

☐ Yes ☐ No

137 **13. Is the residential stay voluntary?**

☐ Yes ☐ No

138 **14. What is the main purpose of the residential stay?**

☐ (1) temporarily remove from home
☐ (2) alternative to incarceration
☐ (3) intensify counseling experience
☐ (8) other (specify): _____

● DOCUMENTATION

1. Please indicate below what client data you *routinely collect* and whether you summarize it monthly, quarterly, and/or annually.

	DATA	Collected YES	Collected NO	Summarized MONTHLY	Summarized QUARTERLY	Summarized ANNUALLY
139–142	Referral source					
	Offense record of Identified Patient					
	Age of Identified Patient					
	Ethnic group/race of Identified Patient					
	Sex of Identified Patient					
	Education of Identified Patient					
	Presenting problem					
167–170	Family composition					
	Date of initial contact					
	Number of contacts					
	Length of service					
	Treatment goals					
187–190	Services provided					
	Service referrals					
	Case notes					
	Reasons for termination					
	Follow-up data					
207–210	Other (please specify): _____					

211 **Are data stored on a computer?** ☐ Yes ☐ No

2. Who receives your routine progress reports?

	ENTITY	Receives? YES	Receives? NO	What Reports? MONTHLY	What Reports? QUARTERLY	What Reports? ANNUAL
212–215	State Criminal Justice Planning Agency					
216–219	Local Criminal Justice Planning Agency					
220–223	State Social Service Agency					
224–227	Local Social Service Agency					
228–231	Other Funding Source (Please specify):					
232–235	Other (Please specify): _____					

3. Indicate which of the following evaluation activities occur in your agency:

236, 237
☐ (1) evaluation conducted by outside contractor you select
☐ (2) evaluation conducted by outside contractor selected by funding source
☐ (3) evaluation conducted by local or state criminal justice planning agency
☐ (4) built-in evaluation as part of program operations
☐ (7) none
☐ (8) other (please specify): _____

238 **4. If an evaluation of your program by an outside contractor has been conducted, please indicate:**

Name of evaluator/firm _____
Address _____
Date of evaluation _____

5. Have you ever in the past or are you currently conducting or participating in any research on family counseling?

239 ☐ Yes ☐ No

If yes, briefly describe: _____

6. Have you ever participated in a survey such as this?

240 ☐ Yes ☐ No

If yes, when: _____ **Who conducted?** _____

● STAFF CHARACTERISTICS

1. Of the staff members who provide family counseling services to client-families, indicate how many are:

	CATEGORY	NUMBER
241–243	1. Paid and full-time	
244–246	2. Paid and part-time	
247–249	3. Volunteer and full-time	
250–252	4. Volunteer and part-time	
253–255	5. Interns	
256–258	6. Independent consultants	
259–261	7. Other (specify): _____	

2. Rate the frequency with which your family counselors use each of the approaches shown below, using the following scale:

1 = Very often 2 = Often 3 = Rarely 4 = Never

262 _____ Communications (Satir, Jackson)
263 _____ Systems Family Therapy (Bowen)
264 _____ Structural/Strategies (Minuchin, Haley)
265 _____ Other (specify): _____

3. In the space below, please describe the backgrounds of those members of your staff who provide family counseling. If more than five people provide this service, select five "representative" counselors.

	Counselor	Degree:	Field	Years of Experience in Family Counseling	Length of Time with Your Agency	Paid (1), Volunteer (2) or Intern (3)	Holds License (1) or Certification (2)	Special Training in Family Counseling (List institutes or workshops attended.)
266–275	1							a.
								b.
								c.
276–285	2							a.
								b.
								c.
286–295	3							a.
								b.
								c.
296–305	4							a.
								b.
								c.
306–315	5							a.
								b.
								c.

316

4. Do you have an on-going family counseling training program?

☐ Yes ☐ No

If yes, please describe: _____

317

5. Do you provide peer supervision of family counseling for staff?

☐ Yes ☐ No

318

6. Does your project/agency have an allocated budget for staff training in family counseling this year?

☐ Yes ☐ No

If yes, what is the amount and source(s) of these training funds?

319–327 $_____ Source _____

328–336 $_____ Source _____

337–345 $_____ Source _____

346 **Any non-financial or volunteer support?** ☐ Yes ☐ No

Please describe: _____

CLIENTS

These questions attempt to describe the client-families who are **referred by** or **diverted from** the **criminal justice system** and who receive some form of **family counseling** from your program/agency. (These are the same client-families counted in screening question C on page 1.)

347 **Note:** Your records may not permit you to easily separate these client-families from others who receive family counseling. Other sources may contain these data (e.g. reports submitted to a funding agency, vouchers, etc.) in a somewhat different form. Please examine alternative sources for responses to these items. If you use one of these sources, please indicate by placing an **X** in the following space _____.

348 **Note:** On the other hand, if no alternative sources of data are available, your responses may reflect your "general sense" about the criminal justice population that receives family counseling. If you use this method of responding to the items, please place an **X** in the following space_____.

The family member whose behavior precipitated the referral or diversion to your program/agency will be referred to as the "identified patient."

1. Approximately what proportion of these client-families are *referred* from each of the following sources:

349–362 / 363–372

_____ Juvenile Court
_____ Criminal Court
_____ Family Court
_____ Police Department
_____ Probation Department
_____ Parole Department
_____ School
_____ Community Mental Health Center
_____ Social Service/Welfare
_____ Other Counseling Center
_____ Self-Referred
_____ Other (please specify):
_____
_____

373–375 **2. Approximately what proportion are *ordered or mandated* for treatment by the courts?** _____

376–385
386–393

3. What types of presenting complaints are represented by these client-families? Check all that apply: place a * next to the most common.

JUVENILE IDENTIFIED PATIENT	ADULT IDENTIFIED PATIENT
____ incorrigible	____ drug/alcohol-related problem
____ runaway	____ assault
____ truancy	____ burglary
____ other school-related problems	____ robbery
____ vandalism	____ rape
____ assault	____ child abuse
____ shoplifting	____ spouse abuse
____ robbery	____ other (please specify): _____
____ rape	_____
____ other (please specify): _____	_____

394–404
405–417
418–421

4. Approximately what proportion of the Identified Patients are:

a. Age	b. Race/Ethnic Group	c. Sex
____ 13 or under	____ White	____ Male
____ 14 to 17	____ Black	____ Female
____ 18 to 25	____ Hispanic	
____ 26 or older	____ Oriental	
____ Not available	____ Other (please specify): _____	
	____ Not available	

422–438

5. Approximately what proportion of the Identified Patients are living:

____ with both natural parents	____ in mixed-type families (one natural parent and one step-parent)
____ with adoptive parents	____ in a foster home
____ with mother only	____ in some other situation
____ with father only	____ not available

● INTAKE AND ASSESSMENT

Again, our focus is on only those client-families who are referred by or diverted from the criminal justice system and who receive family counseling from your program/agency.

439
440–441
442–443
444–445

1. Are there any entry requirements (e.g., age, gender, offense) for your program/agency that apply to these cases? ☐ Yes ☐ No

If yes, please describe: _____

446, 447, 448

2. When dealing with these client-families, does your program/agency use a structured intake or pre-service assessment procedure to:

	a. decide whether to accept a case	b. determine the general treatment plan	c. collect uniform case data
(1) Always	☐	☐	☐
(2) Sometimes	☐	☐	☐
(3) Never	☐	☐	☐

If yes, describe briefly (e.g., tests, parent interviews, family interviews):

449–450 **a.** _____
451–452 **b.** _____
453–454 **c.** _____

455
456
457

3. Indicate the nature of program/agency contacts between the time of referral and the beginning of counseling. (Check all that apply):

☐ telephone conversations
☐ client-family receives information (brochures, etc.) about agency
☐ other transition activities _____

458–459
460–461
462–463
464–465
466–467

4. In approximately what proportion of the cases does the intake or pre-service assessment involve "face-to-face" contact with:

_____ the Identified Patient
_____ one or both parents of the Identified Patient
_____ other members of the Identified Patient's household
_____ spouse
_____ other (please specify): _____

468

5. Is the intake or pre-service assessment normally conducted by the same staff person who will provide on-going counseling?

☐ Yes ☐ No, not necessarily

● DIRECT SERVICES

These questions attempt to describe the direct services received by these client-families. Again, your answers should describe the service pattern typical of client-families diverted from or referred by the criminal justice system who are receiving some type of family counseling.

469–470
471–472
473–474

1. In approximately what proportion of these cases is family counseling:

_____ the only treatment
_____ a primary component of treatment
_____ a secondary or supportive component of treatment

475–476
477–478
479–480
481–482
483–484

2. In approximately what proportion of these cases is the method of payment from:

_____ client to agency
_____ an insurance company
_____ the court to the agency
_____ a community agency (e.g., United Way, CMHC)
_____ other (please specify): _____

3. What other direct services are provided for these clients?

	CHECK HERE IF THIS SERVICE IS USUALLY A PRIMARY COMPONENT OF TREATMENT (1)	CHECK HERE IF THIS SERVICE IS USUALLY A SECONDARY COMPONENT OF TREATMENT (2)
a. Counseling Services		
485 Individual counseling for Identified Patient	☐	☐
486 Individual counseling for other family members	☐	☐
487 Group counseling for Identified Patient	☐	☐
488 Group counseling for other family members	☐	☐
489 Couples counseling	☐	☐
490 Other	☐	☐
b. Educational/Vocational Services		
491 Parenting education	☐	☐
492 Job/career counseling	☐	☐
493 Tutoring	☐	☐

3. (b.) continued

		PRIMARY COMPONENT OF TREATMENT (1)	SECONDARY COMPONENT OF TREATMENT (2)
494	Vocational training	☐	☐
495	Job placement	☐	☐
496	Alternative schooling	☐	☐
497	Other _____	☐	☐

c. Other Support Services

498	Self-help group for Identified Patient	☐	☐
499	Self-help group for other family members	☐	☐
500	Financial assistance	☐	☐
501	Food/nutrition assistance	☐	☐
502	Youth advocacy	☐	☐
503	Recreational program	☐	☐
504	Legal assistance	☐	☐
505	Homemaker assistance	☐	☐
506	Other (please specify): _____	☐	☐
	_____	☐	☐

4. In general, would you say that client services for these client-families tend to divide into two or more distinguishable stages? (examples of stages would be residential treatment followed by out-patient counseling; work on the immediate crisis followed by more general work on improving family functioning; intensive counseling during crisis followed by a tapering off follow-up period of less frequent contact.)

507 ☐ Yes ☐ No

If yes, please describe the stages: _____

_____

_____

5. In general, how frequently are these client-families seen for *family counseling:*

		NUMBER
508-509	During your first stage	_____ times per month
510-511	During your second stage	_____ times per month
512-513	During your third stage	_____ times per month
514	_____ not applicable (no perceived stages)	

6. What is the average length of a *family counseling session* for these client families?

515
☐ (1) less than 45 minutes ☐ (3) 1½ to 3 hours
☐ (2) 45 minutes to 1½ hours ☐ (4) more than 3 hours

7. Approximately what proportion of these client-familes receive *family* counseling for a total of:

516-521 _____ 1 session _____ 6-12 sessions
522-525 _____ 2 sessions _____ more than 12 sessions
_____ 3-5 sessions

8. Approximately what proportion of these cases remain on the active caseload:

526-531 _____ less than 1 month _____ 7-12 months
532-535 _____ 1-3 months _____ more than 12 months
_____ 4-6 months

9. Approximately what proportion of these cases experience the following time lapse between first contact and initiation of treatment services?

536-539 _____ less than 24 hours _____ 4-7 days
540-543 _____ 1-3 days _____ more than 7 days
544 _____ no data available

10. Approximately what proportion of these client-families drop out or prematurely terminate treatment? 545-546 _____

11. In general, what do you consider to be your program/agency's greatest problems in delivering family counseling services to these client-families? Place a number "1" in front of the greatest problem and a "2" in front of the next greatest problem. (check two)

547-548 _____ (1) failure to reach clients because the criminal justice system or school authorities do not always refer all the cases that would be appropriate
549-550 _____ (2) failure to reach referred clients because clients are not supported through the referral process
551-552 _____ (3) failure to engage clients in ***family*** counseling because clients are too resistant to redefining the problem as a family problem — will only accept individual counseling
_____ (4) family members reject counseling altogether
_____ (5) treatment ***is not*** mandated by the courts; therefore, families do not feel obligated to come
_____ (6) treatment ***is*** mandated by the courts; therefore families feel coerced, unwilling to involve themselves in the change process
_____ (7) clients simply fail to show up for sessions
_____ (8) forced to turn away clients or see clients for too few sessions because of programmatic restrictions, personnel shortages, or excessive caseloads
_____ (9) staff are not sufficiently trained to deliver best quality family counseling; inadequate funds for staff training
_____ (10) quality and kind of counseling are too variable from staff member to staff member; no strong centralized agency focus to direct treatment
_____ (11) unable to assess client outcomes, evaluate and improve program functioning because there are no adequate resources for follow-up work with clients
_____ (12) change in offender's status affects participation in program (e.g., adolescent commits new offense and is sent to a different treatment/correctional facility
_____ (13) adolescent offender runs away
_____ (14) other (please describe):

553 **12. Are there any unique or distinguishing features of your program/agency that you would like us to know about?**

☐ Yes ☐ No

If so, please describe:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

IF WE WOULD LIKE TO DISCUSS THE RESPONSES TO THIS QUESTIONNAIRE, WHOM SHOULD WE CONTACT?

Name _____ **Phone No.** _____

END