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### Effective Implementation of a Family Centered Treatment Approach with High Risk Youth and their Families.

Tim Wood

*Family Centered Treatment Foundation*, [tim.wood@familycenteredtreatment.org](mailto:tim.wood@familycenteredtreatment.org)

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# Effective Implementation of a Family Centered Treatment Approach with High Risk Youth and their Families

TIMOTHY WOOD, LPC; WILLIAM TALBERT, QP

NATIONAL YOUTH AT-RISK CONFERENCE

MARCH 9, 2016





“The recent de-incarceration trend provides a unique opportunity to implement resources to delinquency that are more cost-effective and humane, and provide better outcomes for youth, their families and communities.”

*-Annie E. Casey Foundation, 2013*



# Family Centered Treatment Foundation, Inc.



A 501 (c) (3) charitable, not-for-profit, purveyor of evidence-based practices, and social entrepreneurship.

## **It's Our Belief-**

The FCT Foundation endorses the belief that evidence-based practices develop individualized and clinical practice guidelines of best practices to inform the improvement of whatever professional task is at hand.

Clinical practice theory and guidelines, while typically derived from sound beliefs, are often poorly developed or ineffectively implemented. To ensure the greatest results in clinical outcomes, as well as bringing programs to scale, FCT Foundation is steadfast in guiding organizations in development of new or existing practices and theories.

# Objectives

Highlight a researched clinical practice model

Outline existing best practice in Implementation Science

Link how practice and implementation are measured and combine for effective results

# Outline

- ▶ Brief Overview of the highlighted model
- ▶ Best Practices in Implementation Science
- ▶ Does your organization/school monitor implementation development?
- ▶ Putting clinical practice into real-world systems-achievable outcomes. Does this method work?



# The Family Centered Treatment Model



# An EBP Model for Home-Based Services

Family Centered Treatment<sup>®</sup> was developed as a model of treatment for use in the provision of rigorous home-based services.

FCT origins derive from practitioners' efforts to find simple common sense solutions for families faced with forced removal of their children from the home or dissolution of the family due to external and internal stressors and circumstances.

Out of a desire and mission to create opportunity for lasting change for families that were seemingly stuck in a downward spiral, grew a practice approach that is non-traditional, yet grounded in the use of treatment components that are sound and research based. Eco-Structural Family Therapy, Emotionally Focused Therapy, and the Peers Helping Peers model provide the theoretical framework from which FCT has developed.



# *Principles-How does it work?*

- ▶ With the whole family as defined by the family
- ▶ Meet in *their home* at days of the week and times of day that are convenient for the family.
- ▶ Session schedules get the clinician involved during the most troublesome and difficult times and as they occur.
- ▶ Provides **24/7** on call crisis support for the family with their known clinical staff. (not a universal on-call system)
- ▶ Multiple hour sessions several times per week become the norm for creating change.
- ▶ Provides opportunities for the family to *practice* functioning differently. These weekly "enactments" are integral to the process. (not just talk therapy)
- ▶ No reject/eject policy across all licensed organizations
- ▶ Emphasis on Value-based change (Internalization), not compliance is critical to achieving sustained results

# The Origins and Framework of FCT

- ▶ Treat Families with Dignity and Respect
- ▶ Honor the Function of Behavior
- ▶ Treatment that is Relevant and Useful
- ▶ Internalization over Compliance
- ▶ Power of Giving
- ▶ FCT is a tripartite model (clinical, supervisory, organizational)

# Framework

**Treatment aims to strengthen emotional bonds through interactions, self & empathetic understanding of emotional responses.**

**FCT clinicians assist in challenging long held perceptions and patterns of the family enabling new responses towards each other.**

**Family is guided to bring new meaning and understanding of members behavior. By identifying the emotional responses that may be outside of normal awareness, members are able to witness different levels of understanding.**

**Highlighting the change events and responses to change form more secure bonds between family members.**

# Why This Framework?

Countless studies support with evidence the need for family attachment and the need to remain together. Further evidence suggests the need for emotional recognition beyond behavioral change.

Those who felt close to and could depend on [family] reported feeling less angry with and attributing less malicious intent to [family]. They describe themselves as....expressing more positive goals, such as solving the problems and reconnecting with their [family].

( Mikulincer, Orbach 1985)

“Traditional interventions, which do not teach parents how to successfully engage the child, frequently do not provide the means by which the child can form the secure attachment that underlies behavioral change. “

-Daniel A. Hughes

“many children now [in] foster care would be far better off if they remained with their own families even if those families got only the typical help (which tends to be little help, wrong help, or no help) commonly offered by child welfare agencies.”

-*The Evidence is In: Foster Care vs. Keeping Families Together: The Definitive Studies* – National Coalition For Child Protection Reform <http://nccpr.info/>

# Framework-Trauma Treatment

In 2011, FCT Foundation partnered with Richard Kagan of the NCTSN to co-design the FCT Trauma Treatment component. This component was realized and put into practice in 2013 and is currently being utilized nationally within FCT. With the addition of this component FCT is currently being reviewed by NCTSN to be incorporated into their listing as a trauma treatment.

## FCT and Trauma

- FCT is considered **trauma treatment** due to the inclusion of the **emotionally focused therapy** components included.
- Accessing the unacknowledged feelings underlying interactional positions, bringing them to the surface.
- Reframing the problem in terms of underlying feelings, **attachment needs**, and **interactional patterns**
- Promoting identification with disowned needs and aspects of self and integrating them into relationship interactions
- Promoting the acceptance of others' experience and **new interactional responses**
- Facilitating the **expression of needs and wants** and **creating emotional engagement**
- All families have both negative and positive feelings toward each other. Sharing some of these emotions can demonstrate care, concern, and acceptance of one another, while others can create a volatile, intensely emotional reaction of frustration, anger, or discouragement.

# Family Centered Treatment® METHODOLOGY

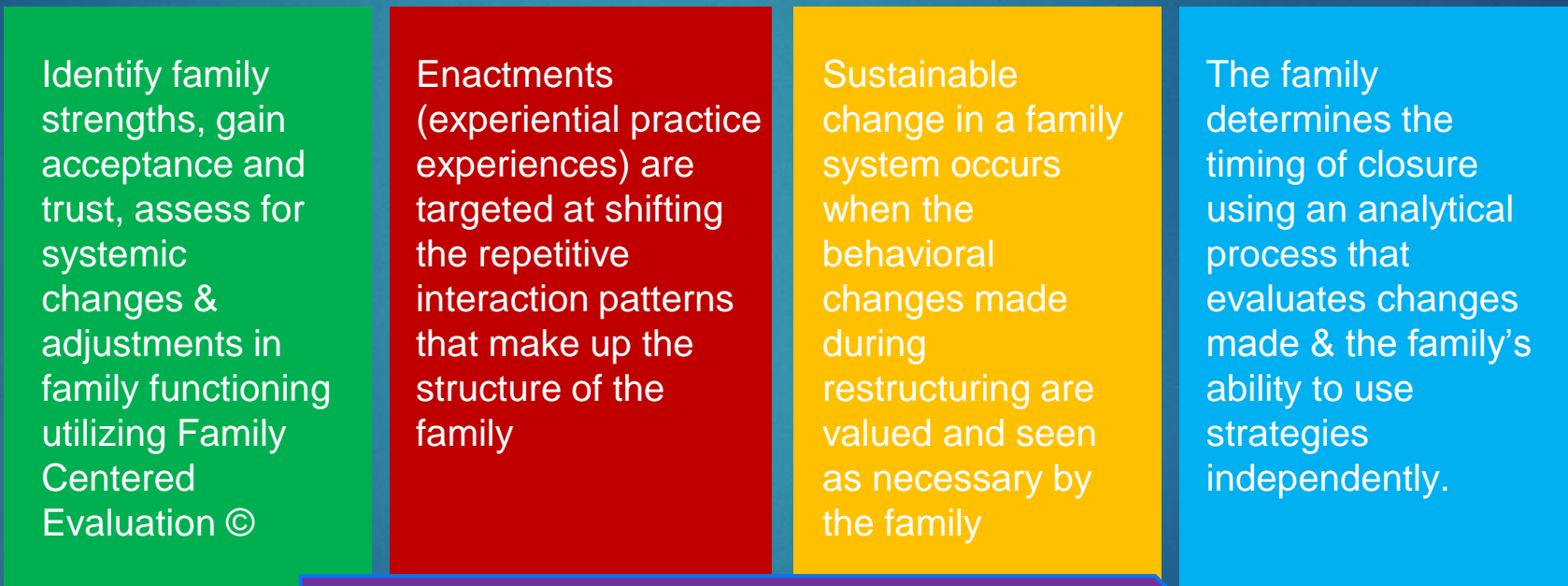
Phase of Treatment



Family Growth



FCT in Action



Referral/Case Transfer

- Initial Session
- CFTM/Tx team roles. **Hierarchy of needs**
- Initial Safety Planning (PRN)
- Acquirement of relevant case history/concerns

Joining and Assessment  
30-45 days

- Engagement and understanding of guarantees
- FCE Experiential Assessment Tools (4) *Crisis Cards, Ecomaps, FLC, and Structural Family Assessment*
- Case consultations with supervisor and team
- Development of Family Centered Service Plan (measurable goals for treatment)
- Addressing comprehensive family needs and resources

Restructuring  
2-5 months

- Family sessions targeted at changing interactions through guided practice
- Addressing emotional blocks and trauma that are a functional cock in the systems ability to move forward
- Gaining an understanding of inherent worth as a family
- Assisting the family in linking to resources and supports.

Valuing Change  
1-2 months

- Continued use of enactment process, modified to allow family more independent control over session once they have incorporated changes into their own internal system
- Identifying how and WHY things are different and assessing continued motivation for wanting to continue change. "WHY IS THIS DIFFERENT/EASIER/BETTER?"
- Use paradoxical work to gain understanding of the families insights into change.

Generalization  
1-2 weeks

- Enactments shift on predicting and solving issues independently and how to apply leaned skills for future use
- Coordination of external system needs following treatment, including step down services
- CFTM case closure to assess that all parties are satisfied with treatment and goal measured goal attainment

# Standardization - Management and Supervision

- ▶ **Assure implementation of the model for each FCT client**
- ▶ **FCT therapists receive a combination of peer supervision, individual supervision, field and crisis support**
- ▶ **FCT requires a commitment by management to provide:**
  - ▶ Peer supervision via a weekly team meeting process
  - ▶ Weekly supervision of the therapist to assure fidelity to the FCT model –  
(staff complete standardized forms requiring signatures of the supervisor and therapist)
  - ▶ Monthly staffing of each FCT case utilizing a family systems model of review (MIGS – mapping, issues, goals, and strategies)
  - ▶ 15 Key treatment related documents that must be produced for each case that are critical to each phase of FCT treatment.
- ▶ **Information management system**
  - ▶ that provides a record review, tracking, and maintenance
  - ▶ process producing the data necessary to assure fidelity to the model.



# Referring Families/Children

- **For children age 3-20**
- **there is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; and**
- **there is significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and family multi-stress situations) as evidenced by one or more of the following:**
  - **a step down from a higher level of care**
  - **DSS involvement in the last year**
  - **Juvenile Justice involvement in the last 6 months**
  - **Behavioral health ER visit and/or hospitalization in the last 6 months**
  - **Multiple school suspensions**
  - **Crisis intervention in the last 6 months**
  - **Abuse: physical, verbal, sexual abuse**
  - **Neglect: physical, emotional**
  - **Parent or caretaker that abuses substances**
  - **Parent or caretaker that is a victim of DV**
  - **Parent or caretaker that is incarcerated**
  - **Significant other traumatic event**
  - **This family functioning area of concern is to be cited in the FCT phase I fidelity document, the Family Centered Evaluation©.**

# Referring Families/Children 2

- **FCT is a no-eject, no-reject model!**
- **Requires involvement of a family system (however family is defined)(can be non-related)**
- **Primary focus is not psychiatric or medical.** (Family Centered Treatment can be utilized effectively when illnesses, either medical or psychiatric, are affecting the short or long term functioning of the family system.)
  - Systemic trauma, reunification, family systems work, IIH/MST is denied, AREAS OF FAMILY FUNCTIONING

**Working with families as early as possible in their process in the system**  
**Permanency Plans are in place or being drawn up**  
**Care Coordination and UM are part of the decision tree!**

## Distinct features:

- Added element of Valuing Changes-emphasis on the family taking hold of their service and the changes they are making
- **NOT a client centric model**
- Changes are made by identifying and working on the functions of behavior not the symptoms
- **Use of Family Systems trauma treatment (with secondary trauma (team) element)**
- Use of emotionally focused therapy treatment components
- **Use of Areas of Family Functioning as driving theme of treatment**
- A management model
- **Rigid Implementation Process**



# Implementation Science

WHAT IS IT AND WHY (READINESS)

HOW IS IT MEASURED

WHAT TOOLS CAN BE DESIGNED

# Implementation

**"A specified set of activities designed to put into practice an activity or program of known dimensions"**



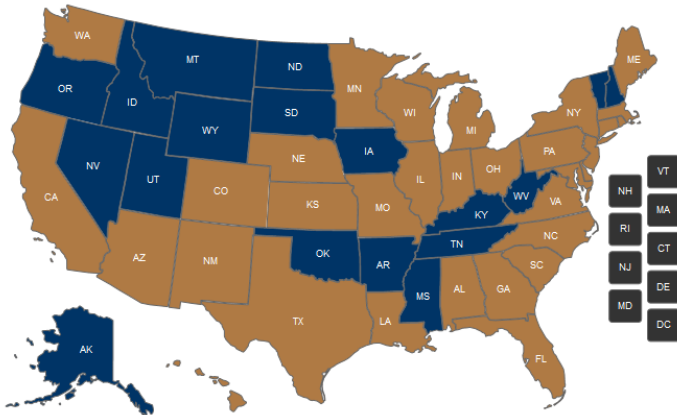
Because even the best ideas need a well thought-out way to achieve it!

Who is exploring? Currently Implementing? Looking for better ways?

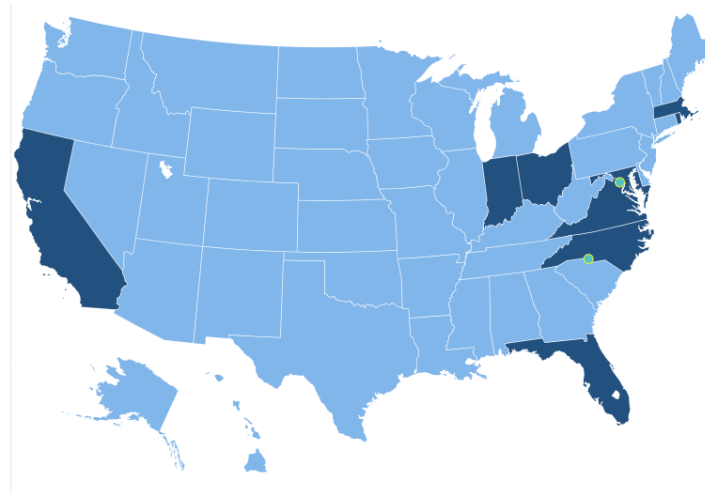


# Replication

## Multi-Systemic Therapy



## Family Centered Treatment



## Functional Family Therapy



Site map images 03/2016, cited from:  
[Msts.services.com](http://Msts.services.com)  
[Familycenteredtreatment.org](http://Familycenteredtreatment.org)  
[Fftllc.com](http://Fftllc.com)

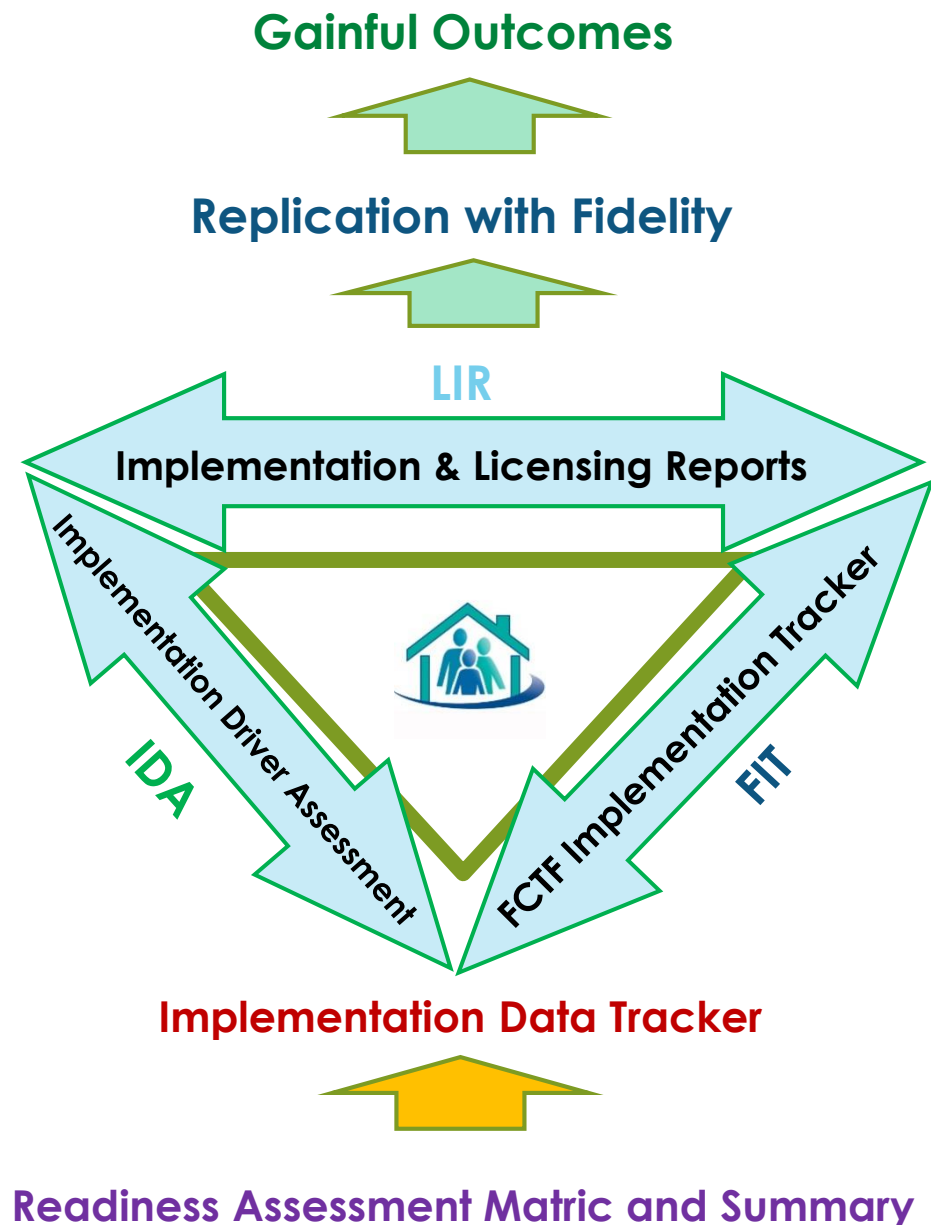
# Replication looks different everywhere





It's STRUCTURE!

It was what we were missing in the beginning!



# Outlining Implementation-Where are you in the process?

## ► Degrees of Implementation:

1. Exploration
2. Installation
3. Initial Implementation
4. *Emergent Implementation*
5. Full Implementation
6. Innovation and Sustainability



These can vary and move depending on changes within FCT organization. FCT specific can take 4-6 years to achieve FI and beyond.

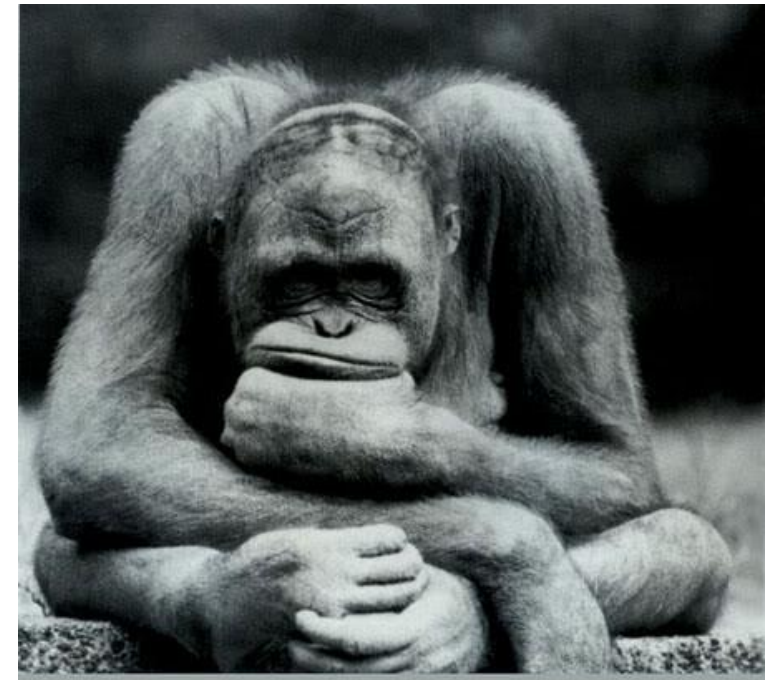
# Exploration and “readiness”

**At this point there are a lot of programs to choose from.?**

- School-based
- Home-based
- Facility

**How intense/what is the target population?**

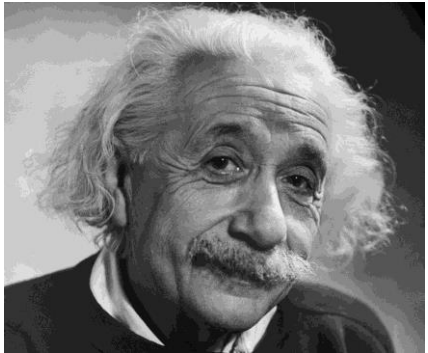
- Daily?
- Monthly?
- High risk-moderate risk-low risk?
- Family based or individual?



Oh what to to, what to dooo?

So you have made a decision

ARE YOU READY?



$$R=mc_2$$

Motivation x General Capacities x Innovation Specific Capacities

# Motivations

- Relative Advantage
- Compatibility
- Complexity
- Observability
- Priority

## ▶ General Capacities

- ▶ Culture, Leadership, Structure, Staffing, Climate for change

## ▶ Specific Capacities

- ▶ Program Champion, inter-organizational support, Innovation knowledge and skills internally, external support



We do not shy away from challenges. Predict them and assess for paper implementation. Use of the FCT Readiness Assessment Matrix

# Installation



“The awkwardness of installation”

What do we do now?

# Implementation Drivers

## 6 Phases of Implementation

Exploration  
Installation  
Initial Implementation  
Emergent Implementation  
Full Implementation  
Innovation & Sustainability

## Implementation Drivers

Leadership  
Competency  
Organizational

## Implementation Teams

Executive Management  
QMS staff  
HR personnel  
External Stakeholder  
Supervisors  
Trainers (L2 and L3)  
Clinical Staff



# Leadership Driver-Culture

- ▶ Determine what the highest level of decision making is within the organization
  - ▶ Often not just a CEO. This means BOD, shareholders.
  - ▶ How do they convey direction and sense or need for implementing. Why are they pushing this particular approach?
- ▶ Who are the power brokers within the organization?  
Who is bringing this in? Who can you make a hero in this? If they leave does the program remain? Why and how?
- ▶ What is the emotional undercurrent of those providing the services?
  - ▶ Is there excitement? Is it fear based?
  - ▶ How is this measured?





# Leadership Driver-**Technical**

- ▶ How are missions defined and solutions generated by leadership within the organization?
  - ▶ What are decisions based on and who is making them?
  - ▶ Do those capable of enacting change have the tools and knowledge base to do so?
  - ▶ Are leaders in the organization content experts? If not, who is trained or brought in?
- ▶ **Quantifying this can also be challenging:**
  - ▶ Does the organization have written plans for training and development of leaders?
  - ▶ Are their strategic plans or contingency plans in place for decision makers.
  - ▶ Can you validate that leaders have the training and knowledge needed to complete the agency goals.
  - ▶ Can organizational leaders internalize and put into place treatment modality specific information/language to resolve issues or push ahead with planning?

# Leadership Driver-**Adaptive**

- ▶ How well is the organization able to step out of the norm to solve problems, reach goals, or enact change?
- ▶ *Giving the work world back* - Creating conditions that help people take greater responsibility for the work of change, including defining and solving the problems. The leader supports staff rather than directing or controlling them. Giving the work back to the people also requires instilling and expressing confidence in others so that they will take risks, and backing them up when they make mistakes.
- ▶ **Quantifying:**
  - ▶ Does the organization allow time for those with knowledge to meet and make decisions. Do they listen?
  - ▶ Are patterns identified and does the organization learn from mistakes? If there a climate of acceptance and opportunity for mistakes.
  - ▶ For missions or challenges, does the organization assign a point person or champion to follow through?

# Competency Driver-Recruitment & Selection

- ▶ The selection process is an important opportunity that allows new hires and reassigned staff to clearly understand the job requirements and ways of work and to make their own decision about whether the programs, practices and continuous improvement processes are a good fit for them.
- ▶ The potential for drift or delays is huge here is not executed properly.
- ▶ Don't just assess knowledge or competence but COMMITMENT as well. What did you do to prepare today? Why company X over company Z?

## ▶ Quantifying:

- ▶ How are they selected? Recruiter, Out of necessity?
- ▶ Qualification in alignment?
- ▶ Does existing team have input on selection?
- ▶ Qualifying behavioral rehearsals?



Is it okay to watch a family struggle?  
How would you apologize to a family?

# Competency Driver-Training

- ▶ “We know from implementation research that training alone does not result in changes in instructional practices and improved outcomes. But, training is still an important process to provide background information, introduce skills and major concepts, theory and values of the evidence-based programs and practices. In short, training is necessary for building competency, but it is not sufficient if used alone.”
- ▶ **Quantifying:**
- ▶ Objective and measurable testing and evaluation.
- ▶ Training is timely, useful and relevant.

# Competency Driver-Coaching

- ▶ “Coaching ensures that the fragile, uncomfortable new skills are actually tried in practice. As new [clinicians] get better and better at using their new skills, they become more artful and confident.”
- ▶ Supervision and coaching are integrated with selection and training because the educator will continue to build on what was described in the interview process and what was covered during training. And coaching helps to compensate for the skills and abilities that were not present at the point of hire or that were not mastered in training.

- ▶ **Quantifying:**

- ▶ Direct observation of skills

TRAINING COMPONENTS	OUTCOMES		
	% of Participants who Demonstrate Knowledge, Demonstrate New Skills in a Training Setting, and Use new Skills in the Classroom		
	Knowledge	Skill Demonstration	Use in the Classroom
Theory and Discussion	10%	5%	0%
...+Demonstration in Training	30%	20%	0%
...+ Practice & Feedback in Training	60%	60%	5%
...+ Coaching in Classroom	95%	95%	95%

Source: Joyce, B., & Showers, B. (2002). *Student achievement through staff development* (3rd ed.). Alexandria, VA: Association for Supervision and Curriculum Development.

# Competency Driver-Performance Assessment

- ▶ Assessing fidelity at the teacher/practitioner level is imperative to interpreting outcomes. If we don't assess fidelity, then we cannot:
  - ▶ be sure an intervention was actually used,
  - ▶ attribute outcomes to the use of the intervention, or
  - ▶ know what to focus on to improve.
- ▶ **Quantifying:**
  - ▶ Define the fidelity in quantitative and qualitative terms. Track electronically
  - ▶ Define fidelity in measurable terms such as engagement, time, process completion, etc.

# Organization Driver-Systems Intervention

- ▶ The Systems Intervention Driver is focused on the external variables, policies, environments, systems or structures that influence or have impact on an implementing organization. Building and district leaders and teams identify barriers that are beyond their level of authority and work to bring issues to the attention of those who can address such barriers.
- ▶ The ability to make all members of the system feel like they make a difference.
- ▶ **Quantifying:**
  - ▶ Funding trends
  - ▶ Communication trends and frequency

# Organization Driver-**Facilitative Administration**

- ▶ internal processes, policies, regulations, and structures over which a school, district or implementing organization has some control.
- ▶ create and maintain hospitable environments to support new ways of work. Administrative systems are accountable for creating an organizational context that is supportive, engaged in learning, and continuously improving based on best practices and the use of data.
- ▶ **Quantifying:**
  - ▶ Structural hierarchy
  - ▶ Policies and procedures that enable practice



# Organization Driver- QM System

- ▶ Create and maintain hospitable environments to support new ways of work.
- ▶ Administrative systems are accountable for creating an organizational context that is supportive, engaged in learning, and continuously improving based on best practices and the use of data.
- ▶ **Quantifying:**
  - ▶ Electronic data tracking
  - ▶ Frequency that data is disseminated appropriately to those involved
  - ▶ Internal and external audits

# Tools

RAM-IDA-FIT-FACT



# What can be achieved

CLINICAL AND IMPLEMENTATION OUTCOMES



- 9 States
- 12 Licensed Organizations
- >35 Sites



# 2015 annual reports

- ▶ Currently >300 Certified clinicians across 9 states
  - ▶ Additional 65 in training
  - ▶ 2015 saw > 1,600 families receive FCT
  - ▶ 6 'new' FCT sites
  - ▶ 76% of highest 'risk' families maintained placement or were reunified.
  - ▶ Fidelity to the model of families completing treatment >90%.

# Empirical Evidence-2015

## SUMMARY OF YOUTH OUTCOMES FOLLOWING FAMILY CENTERED TREATMENT® IN MARYLAND

- ▶ Sample: Youth adjudicated delinquent (DJS-involved)
  - ▶ 1,246 Maryland FCT participants FY 2009-2013
  - ▶ 1,441 statistically matched youth in group homes/treatment group homes
- ▶ Outcomes
  - ▶ Measured from end of treatment to study end date of June 30, 2014)!
  - ▶ Re-adjudication or commitment to DJS
  - ▶ Adult conviction or sentence of incarceration (includes suspended sentence)
  - ▶ Cost of service provision in FCT and group care
  - ▶ No eject-No reject for all participants and included non starters!



**FAMILY CENTERED  
TREATMENT®**



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SCHOOL OF SOCIAL WORK

*Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2015). Summary of Youth Outcomes Following Family Centered Treatment® in Maryland. Baltimore, MD: University of Maryland School of Social Work.*

# Empirical Evidence-2-2015

- ▶ Adult conviction after discharge from treatment
  - ▶ 22.7% in FCT group; 27.3% of youth in group homes
  - ▶ Statistically significant (hazard ratio = 0.75,  $p < .001$ )
- ▶ Sentence of incarceration (including suspended sentences) after discharge from treatment in some cases up to 12 years.
  - ▶ 21.4% in FCT group; 26.0% of youth in group homes
  - ▶ Statistically significant (hazard ratio = 0.74,  $p < .001$ )
- ▶ With shorter lengths of stay and a lower daily cost, the initial intervention cost for FCT was \$30,170 less per youth than group home placement for a statistically equivalent comparison group, on average.



**FAMILY CENTERED  
TREATMENT®**



UNIVERSITY of MARYLAND  
SCHOOL OF SOCIAL WORK

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# Questions?

[www.familycenteredtreatment.org](http://www.familycenteredtreatment.org)


<http://implementation.fpg.unc.edu>

[info@familycenteredtreatment.org](mailto:info@familycenteredtreatment.org)





# Acknowledgements and Citations



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*Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2015). Summary of Youth Outcomes Following Family Centered Treatment® in Maryland. Baltimore, MD: University of Maryland School of Social Work.*

Source: Joyce, B., & Showers, B. (2002). *Student achievement through staff development* (3rd ed.). Alexandria, VA: Association for Supervision and Curriculum Development.

BRIDGING RESEARCH AND PRACTICE The ISF, Organizational Readiness and 100 Million Healthier Lives; Abraham Wandersman University of South Carolina  
27 May 2015

Painter, William E. Jr., Smith, L. "Bob" , "The Definitive Report for Family Centered Treatment" unpublished manuscript, FCTDefinitiveReport.pdf

