

## Family Centered Treatment®:

### A Community-Based Alternative to Out-of-Home Placement



Hosted by the Coalition for Juvenile Justice

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## Purpose of the Presentation

For many states home-based services have become the primary method of public sector intervention for families experiencing functioning difficulties. It has been said that regardless of initial intent most models that are practiced end up being, by design or default, client centered. When such occurs, the intense work is with the client and the stabilizing and factor enabling change is the client's relationship with the worker. Such can be temporarily successful yet result in poor long term outcomes without impacting the family. It is Family Centered Treatment's contention that in order for change to be sustainable, work must be with the whole family. **This EBP model guides families through a change process that challenges the family to demonstrate their value of the changes they have made. Thus the aim Family Centered Treatment® is to enable long term sustainable change rather than changes that are short term and performance based. In this presentation we examine if FCT succeeded in a large scale and long term independent evaluation as well as some of the model components of FCT.**

## Topics covered and by whom

- ✓ The reason for the services and how Maryland DJS made this happen – John Irvine;
- ✓ The licensing agency of the treatment model selected – Tim Wood; Executive Director Family Centered Treatment Foundation
- ✓ The Independent Evaluation – Charlotte Bright; University of Maryland School of Social Work
- ✓ The model components and implications of the findings – Bill Painter; Senior Director Clinical Practice - Child and Family Services Center of Excellence with the MENTOR Network

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## Handouts include:

- Executive Summary of the independent evaluation
- Family Centered Treatment Brief Description
- Family Centered Treatment Methodology

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## *Family Centered Treatment Sustainable Change*



LONGEVITY  
COURAGE

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### **DJS: A Broad Scope of Authority Over Maryland Juvenile Services**



- ✓ Intake
- ✓ Detention
- ✓ Detention Alternatives
- ✓ Pre-Court Diversion  
(Court: Adjudication)
- ✓ Probation
  
- ✓ Committed Programs
- ✓ Aftercare

Community-Based Family  
Therapy Programs:  
FFT, MST, FCT

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## DJS: Community-Based Family Therapy Programs



FFT – Functional Family Therapy  
Average of 173 youth in 12 Counties

MST – Multisystemic Therapy  
Average of 39 youth in 5 Counties

FCT – Family Centered Treatment: Institute for Family Centered Services (IFCS), Inc./The MENTOR Network  
Average of 139 youth in 14 Counties

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## MD DJS Contract for home based services as alternative to residential placements



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## The Family Centered Treatment Foundation, Inc.

- 501c(3) Non profit, charitable incorporation, Founded in 1992 under the name Familifirst.
- Owner and licensing body of the EBP, Family Centered Treatment® and the training manual The Wheels of Change©

**FCTF role:**

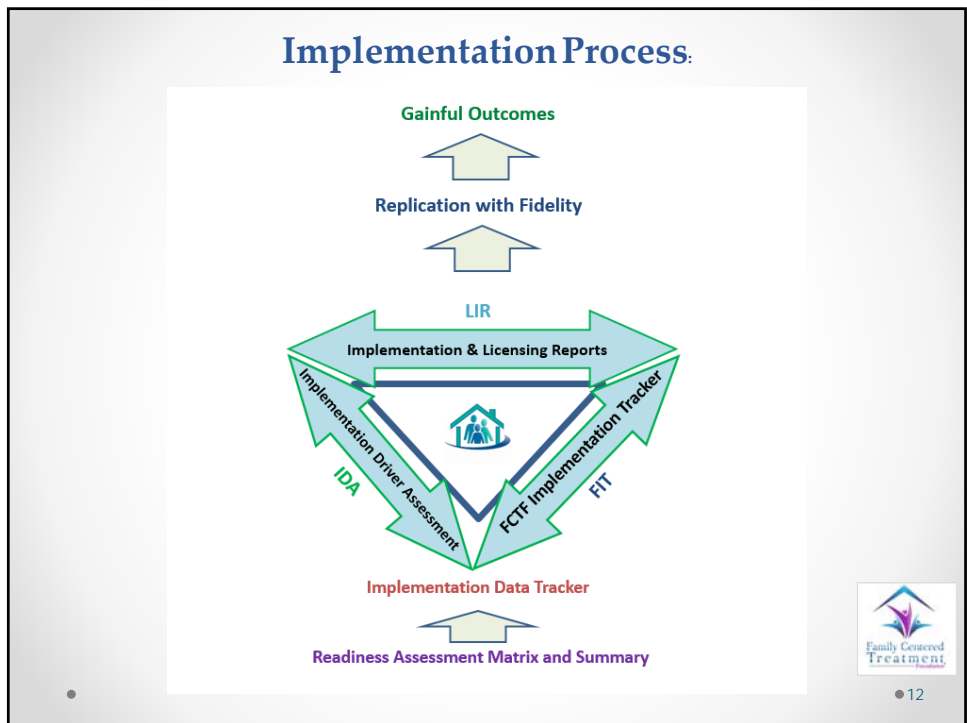
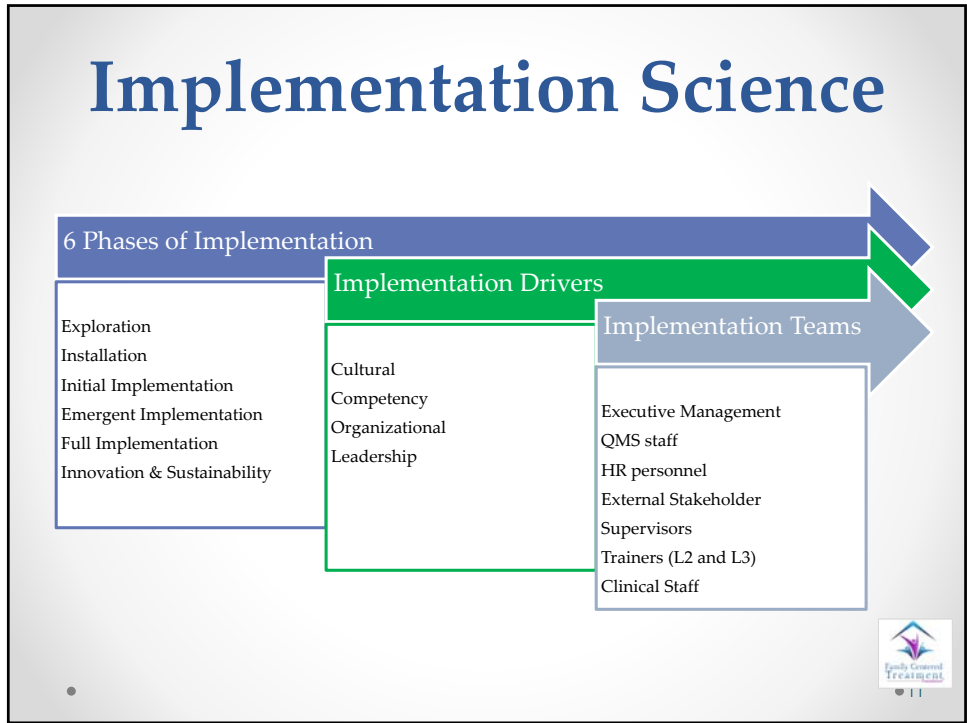
- ❖ Provide Training and Consultation to licensed organizations
- ❖ Provide Monitoring and oversight of FCT standards, fidelity, and outcomes
- ❖ Provide Implementation Science practices catered specifically to sites/states/organizations
- ❖ Support and grow the model through collaborating with independent research bodies
- ❖ The goal of FCTF Implementation is to replicate results with fidelity, while developing an internal organization system capable of self-replication and innovation.

*Enhancing the capability of agencies, communities and state systems of care in the implementation of proven evidence-based programs to address the contemporary needs of families in crisis.*





-FCTF is not a direct service provider-





Key Licensing Standards	Brief Description
Clinical Certification and Training	Organizations are expected to achieve key licensing benchmarks related to training and certification including passing rates via the online and field based training program, Wheels of Change®
Supervisor Certification and Training	FCT Supervisors are expected to achieve licensing benchmarks and undergo the FCT Supervision Curriculum training via the Wheels of Change online and field based training program.
Fidelity and Adherence	FCT organizations are expected to achieve and maintain benchmarks for clinical document production as well as abide by measured quantity and quality of direct time with families.
Clinical outcomes collection and sustainment of measurable benchmarks	FCT organizations are expected to have the capacity to perform data collection for analysis and to maintain discharge outcome benchmarks.
Implementation Process	FCT organizations re expected to follow a catered and specific implementation plan for their organization following the process to ensure site replication with reliability.

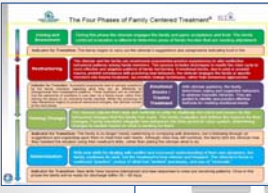



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## Training and Certification of FCT Clinicians


- **Wheels of Change® Training Program**


- The intensive standardized training process has been in place for FCT since 2004.
- WOC was revised in 2009, to include an on line, participatory course with testing video demonstration and quick feedback. It was field tested with trainers and management.
- The training for FCT is a competency-based certification process that incorporates 3 phases:
  - 1) an online knowledge and theory based participatory component,
  - 2) field based experience,
  - 3) an observed field testing of the skills needed to practice the core components of Family Centered Treatment.









## Training and Certification of FCT Supervisors

- 8 Supervision units of online study in the FCT Supervision Certification course provided by the WOC.
  - Direct learning, scenario's with group feedback, and end of unit testing.
- 4 required submissions of video tape or live feedback while supervising clinicians through 4 phases of FCT.
- Required demonstration of use and fidelity to FCT Supervision documents

**DISCUSSION QUESTION:**  
**Alignment with Core Values**

- What elements of your organizations mission statement do you find most consistently demonstrated?
- How and when as a supervisor do you convey your organizations mission to your supervisees?

#AlignmentWithCoreValues

Progress Completed    Current Completion    Watchers/Status

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Completed	70%
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View Advanced Report

**FCT FOUNDATION**  
**JOHN DOE**

**Fidelity Certified Trainer**

Early Coercive Treatment  
The Wheels of Change

## External Evaluation: Methods & Key Findings



## Purpose

- Add to evidence base on Family Centered Treatment®
- Use rigorous methods
- Objective research team
- Three primary aims:
  - Compare recidivism rates between youth in FCT and group care
  - Compare costs of service provision between FCT and group care
  - Explore implementation factors (engagement, dosage, fidelity) in relation to outcomes

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## Sample and Outcomes

- **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

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# Methods

- **Sample construction: matching**
  - *Propensity score matching* – a strategy to create statistical equivalence across different groups
  - We “matched” group home (GH) youth with similar characteristics to the FCT youth in the sample
  - Matching resulted in a sample of GH youth who were not significantly different than FCT youth on background characteristics
  
- **Outcome data analysis: time-to-event models**
  - Statistical models allow for consideration of time at risk
  - Also known as survival analysis (in this case, Cox regression)

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# Matched Sample Characteristics

*Demographic Characteristics of Matched Sample, Youth Admitted to FCT and Group Homes, FY09-FY13*

	FCT	Group Homes
<b>Total</b>	1246	1441
Female	21%	25%
Male	79%	75%
African American/Black	67%	71%
Caucasian/White	27%	23%
Hispanic/Latino	5%	5%
Other	1%	1%
Mean Age (SD)	16.6 (1.4)	16.4 (1.3)
Urban	13%	24%
Suburban	53%	44%
Large Town/Rural	34%	31%

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## Aim 1: Juvenile Recidivism Findings

- **Re-adjudication after discharge from treatment**
  - 12.8% in each group
  - Difference not statistically significant (hazard ratio = 0.89,  $p > .05$ )
- **Commitment to DJS after discharge from treatment**
  - 6.3% in FCT group; 8.7% of youth in group homes
  - Statistically significant (hazard ratio = 0.61,  $p < .001$ )

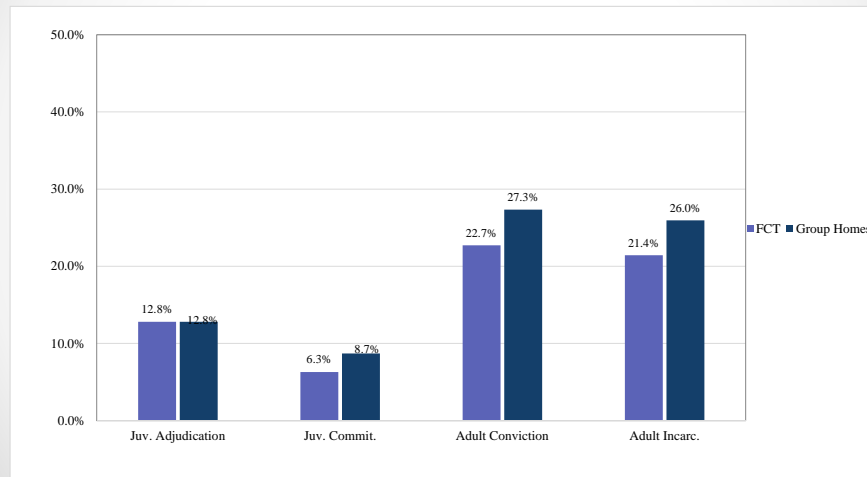
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## Aim 1: Adult Recidivism Findings

- **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**
  - 21.4% in FCT group; 26.0% of youth in group homes
  - Statistically significant (hazard ratio = 0.74,  $p < .001$ )

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## Aim 1: Juvenile & Adult Outcomes



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## Aim 2: Cost Findings

- FCT intervention costs, on average, **\$30,170** less per youth than group homes
- Cost difference reflects:
  - Shorter average lengths of treatment (151 days FCT, 201 days group homes)
  - Lower average daily cost (\$80/day FCT, \$210/day group homes)

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## Summary of Evaluation Findings

- FCT in Maryland is associated with better outcomes than group homes on 3 outcomes: DJS commitment, adult conviction, adult incarceration
- FCT is not significantly different from group homes on DJS re-adjudication
- FCT costs are lower than group home costs – lower per diem and shorter treatment

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## Evaluation Team

Charlotte Bright, PhD – principal investigator

Jill Farrell, PhD

Sara Betsinger, PhD

Andrew Winters, MSW

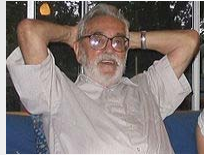
Daryl Dutrow, MSW, MBA

Bethany Lee, PhD

Jenny Afkinich, MSW

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# Theoretical Framework



Salvador Minuchin



Sue Johnson

Comprehensive and intensive home-based model  
 Developed over 20 years  
 Continuously refined through research, experience,  
 and feedback from clients.

Although developed from applied success, some of the critical components that provide the theoretical framework are recognizable as derivatives of major models of evidenced based practice such as:

Eco-Structural Family Therapy

and

Emotionally Focused Therapy/ Sensory based Trauma Treatment

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## 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).

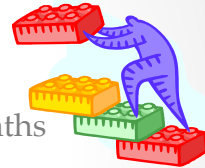


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## Essential Components

The primary stages or phases of FCT are:

Joining and Assessment  
 Restructuring  
 Value Change  
 Generalization



Typical length of treatment is 6 months

*although*

the process is individualized for each family to attend to their specific needs and the time frame can decrease or increase dependent upon need.

*Trauma Treatment is provided at any phase or juncture of treatment when need is indicated*

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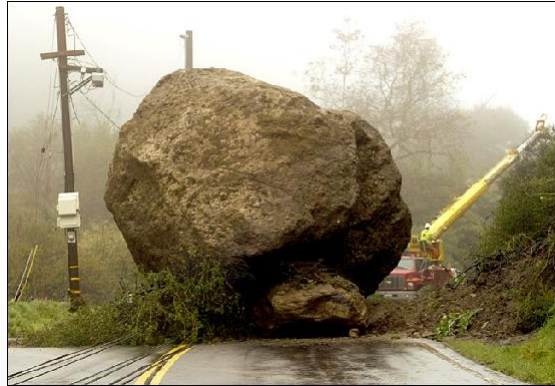
## What is meant by "sustainable change"?



When achieved, sustainable change helps a family move from making conscious "efforts to change" to establishing a new, accepted "way of living".

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## Obstacles ?



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## Engaging the family

**We must connect before we can correct**



- *Privilege; not a right to be in their home*
- *Treatment and change is their choice*
- *Guarantees*
- *Respect and dignity integral to the process*
- *This process is done "with" them; not "to" or "for" them*

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## Phase 1: Joining



FCT clinicians have a clear vision of what the joining phase should look like.



This involves respecting the uniqueness of each family and getting to know their world through their point of view



It includes a notion that “people are people” and with similar needs as we all possess. This approach requires the clinician to gain understanding for the reasons why the family has made the decisions they did. He/she may even feel if given the same resources and conditions, he/she would have come to the same conclusions as the family.



This process allows the clinician to develop an attitude of dignity and respect for the family that eliminates the “one up” position many professionals assume with clients. By doing so, the family opens up and allows the clinician “in”; also known as “joining”.

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## Assessment



Although standardized assessments are utilized (FAD, CANS etc.) the Family Centered Evaluation (FCE) process is specifically designed to be attractive for families that are typically known as highly resistant to engage in treatment.



This is accomplished through the use of participatory assessment activities rather than a standard interview process; Ecomaps, Family Life Cycle and Structural Family Assessment.



The Family Centered Evaluation (FCE) enables the family to discover unhealthy dynamics on their own, as the activities provide an opportunity for them to pull the pieces together rather than expecting the therapist to dictate what needs are to be addressed. This process permits the family to be in “charge” (empowered) and enables their investment in their process for change.



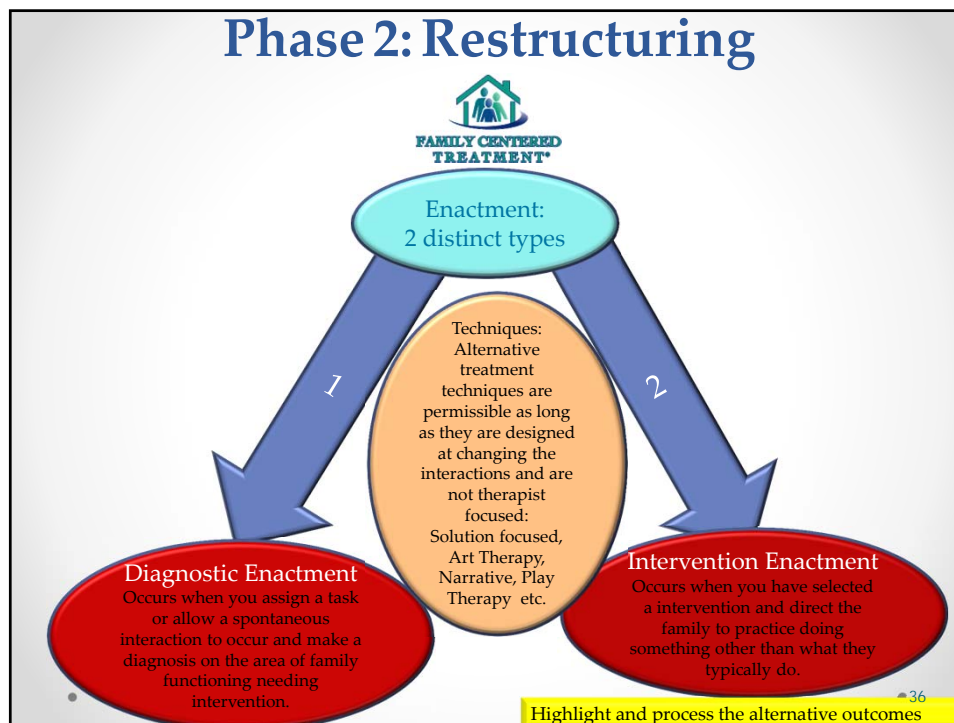
For example; at the end of one of the FCE components, the Structural Family Assessment (SFA), the family is asked to identify goals that represent an honest and real need based upon their own assessment of their level of functioning (what is working and what is not). 34

## Treating the Functions of Behaviors ; not just a behavioral change approach

1. Behaviors are often idiosyncratic and triggered by sensory based perceptions
2. While cognitive ability to understand, articulate and even role play needed behavioral changes may be present, emotional blockages from past pain (trauma) can interfere with the integration of desired changes.
3. To dismiss the client or family member as unwilling or unable to make needed behavioral changes is to place them blame on the client / family.
4. Trauma treatment is needed instead.

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## Phase 2: Restructuring



## Phase 2: Restructuring

Evidence of successful engagement is indicated by the family's follow through on suggestions or homework. These assignments can include the therapist's efforts to get the family to vary their ways of interacting with each other outside of their norm.

This experiential attempt to behave differently is systematically analyzed by the family and the therapist so the family can learn, refine and attempt a new strategy for interacting differently that works for the family (meets their needs).

Once the right strategy is found, the family has the opportunity to practice it with the support and coaching of the therapist. The therapist corrects the family as they slip back into their "old way" of behaving; rapidly accelerating the change process.

A potential pitfall with this approach is that the family might have a significant emotional block that prevents them from behaving in the alternative way. When this is discovered, the therapist must process this emotional block to resolve it enough so the family can practice the alternative behavior.

## Reasons folks change will vary considerably

But which reasons are most likely to enable change that is sustainable?

- Conformity
- Compliance
- Pleasing
- Avoidance of conflict
- Remove the oversight or external power

**If exit or discharge occurs before the client or family “owns” the change what is likely to occur?**



What happens if discharge or exit occurs before change is “valued”?

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## **Valuing Changes** **A distinctive feature of FCT**



- ▶ Family is guided to experience value conflict concerning the behavioral changes that they have made during treatment.
- ▶ Necessary for changes made during treatment to be sustained.
- ▶ Most models terminate services once compliance is achieved.
- ▶ Ironically it is at this juncture that FCT provides opportunity for the family to examine the reason/function of the behavioral changes, thereby increasing the chance that the behaviors will become internalized and sustainable.

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## Phase 3: Valuing Changes

This stage is distinctive of FCT. FCT clinicians are not satisfied with conformity and compliance; FCT goes beyond to assist the family in developing ownership for their new adaptive behaviors by asking them to examine the reasons for making changes *after the behavioral change / restructuring phase*. This leads the family to incorporate the changes into their value system; and therefore, the changes are long lasting.

This ensures sustainability beyond treatment.

Value change is accomplished by the therapist dramatically changing his/her style with the family from highly directive to questioning and shifting responsibility back to them, i.e. "how have you handled this in the past successfully?" "Why don't you try that?"

## Phase 4: Generalization



In this final stage of treatment, the family is guided to make explicit their process of addressing and resolving problems. This phase may take up to one month.



Families that can effectively identify their problems, explore alternative solutions, implement their ideas/solutions, evaluate the effects and revise their responses, when needed, tend to negotiate through stages of family life well.



In this phase therapist must make this process of solution focused self determination (just described) very clear for the family. This must occur in order that the family can use this process to address the expected and unexpected future challenges effectively.



The Generalization phase also helps with sustainability by leaving the family with a clear problem solving process to follow when faced with future challenges. This furthers their growth, development and healthy functioning.

*The "Power of Giving" is an fundamental component.  
Positions families to give to others as a method for*



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## Limitations of Practice

- Requires involvement of a family system, however "family" is defined  
(can be composed of non-related individuals living together as a family system)
- Primary focus is not psychiatric or medical.
- Nevertheless, FCT can be utilized effectively when illnesses, either medical or psychiatric, are affecting the short or long term functioning of the family system.



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## Competency Based Training Requiring Certification

### Wheels of Change© Training Program

- A competency-based certification process that incorporates 3 phases:
  - 1) an online knowledge and theory based participatory component,
  - 2) field based experience,
  - 3) an observed field testing of the skills needed to practice the core components of FCT.
- Certification in Family Centered Treatment Supervision
  - 6 month development and certification of supervisors by consultants involving live ,web ex or video observation



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## Competency based supervision



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## Standardization - Management and Supervision

- Assure implementation of the model for each FCT client
- FCT therapists receive an average of 5 hours per week of supervision  
(combination of peer, individual, 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
  - provides a record review, tracking, and maintenance process producing the data necessary to assure fidelity to the model.



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## Fidelity



### Each FCT phase requires specific tools/documents

- effectively assesses fidelity to FCT per client/family
- tracked via electronic information management systems
- enables evaluation of fidelity to the FCT model for each client and worker

### A consistency checklist: an overview of all the fidelity tools required

- 15 Individually designed documents to record the distinct aspects related to each phase of the FCT model (Joining/Assessment, Restructuring, Value Change, and Generalization).
- Supervision provided utilizing supervision and forms that is FCT phase specific; supervision is conducted differently depending upon the phase of treatment involved.

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## Evaluation of Outcomes & Implications



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### This study included a Large sample size and long period of evaluation

- The comparative analyses for the current study included a total of **2,687 youth**; 1,246 youth who started FCT and matched sample of 1,441 youth who were admitted to a group home (GH) or treatment group home (TGH) between FY09 and FY13.
- Outcomes of interest in the juvenile justice system were any adjudication and commitment to DJS post treatment discharge which was **up to 5 years** (post treatment analyses through June 30, 2014).

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## Population Characteristics

- All had Maryland DJS involvement, and all had been adjudicated delinquent prior to beginning services.
- Between the ages of 15 and 17 years old (75%); average age at admission was just over 16 years old.
- All youth were between the ages of 10 and 20 years old.
- The majority of youth were male (79%)
- The majority of youth were African American/Black (67%)
- The largest share of youth resided in suburban jurisdictions (53%), followed by rural (34%) and urban (13%) settings.
- For both youth who started FCT and those admitted to group homes, the first complaint to DJS typically occurred prior to the age of 14.
  - For both groups youth averaged 1.7 prior committed residential placement with DJS placements. Because these groups were matched using propensity score matching (nearest-neighbor, with replacement), differences between groups were non-significant.

Figure 4. Prior DJS Involvement, Matched Sample of Youth Admitted to FCT and Group Homes, FY09-FY13

	FCT	Group Homes
Total	1246	1441
Mean # of Prior DJS Complaints (SD)	5.3 (3.8)	6.7 (4.9)
Mean Age at First DJS Complaint (SD)	13.8 (2.1)	13.4 (2.0)
Any Prior DJS Committed Residential Placements	36%	44%
Mean # of Prior DJS Comm. Res. Placemt. (SD)	1.7 (1.2)	1.7 (1.2)

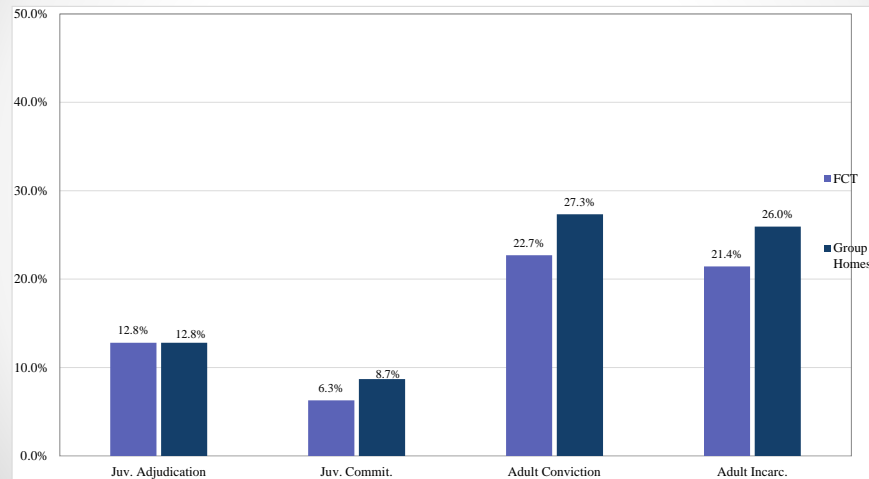
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## Additional Significant Information

- FCT was not developed and tested in controlled, laboratory settings; therefore, it may be considered a homegrown, or provider-developed, model of practice (Lipse, 2012).
- This study is an **effectiveness study (real life implementation)** not an efficacy study (controlled).
- Because of its “no reject/no eject” policy, FCT serves youth with many different sets of risk factors, so long as a parent or caregiver is available to participate. In other words, FCT applies **no exclusionary criteria**.
- Fidelity to the FCT practice model was high, with average fidelity to specified treatment activities **exceeding 75%** in fiscal years 2011-2013 (the years in which fidelity data was consistently captured in client records).
- **Over 85% of the sample met FCT’s definition of engaged** in treatment (11 or more direct contacts).

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## Let's take a look at those results again and the implication of these findings



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## Making sense of these findings.....

- No significance in outcomes in the re-adjudication rates post treatment for those youth that had not aged into the adult system.
- However there was significant difference in commitment rates for the same youth. **Significantly** fewer youth receiving FCT were committed than youth in group care.
- **FCT participants experienced significantly lower rates of both adult arrest resulting in conviction and criminal justice system incarceration than their matched group care counterparts.** This study used the Maryland Department of Juvenile Services definition of adult incarceration, which includes suspended sentences.
- 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.
- For initial intervention costs and any additional residential placement costs during the first 12 months after the start of each intervention, FCT costs were an estimated \$41,729 less per youth

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## Take aways from these findings....

- For a population often considered “lost” and “resistant” to treatment (79% male/75% ages 15-17/63% African American/Black), Family Centered Treatment was proven significantly effective when compared to out of home treatment in preventing commitment to out home placements post treatment (evaluated for some clients up to 5 years post Tx.)
- Following the subset of this population that **aged into adult hood** Family Centered Treatment was proven **significantly effective** when compared to out of home treatment in preventing both re-offense and recommitment.
- And significant for taxpayers and funders/payers these significant results with a challenging population were at a significant savings on average of **over \$30k for the initial treatment and averaging up to over \$40k post treatment.**
- Our assertion is that treatment for the family system is both initially effective and cost saving but when using Family Centered Treatment produces **SUSTAINABLE RESULTS....something we all hope for.**

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## Contact Information

For more information regarding the FCT model, please visit: <http://www.familycenteredtreatment.com>

If you have questions about the webinar content, please contact:

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