Children's Mental Health Task 11 FY 2006:
Family-Directed Structural Therapy Training Project
Year End Report

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EXECUTIVE SUMMARY

During FY 2004 and 2005, University of Kansas staff and Area Mental Health Center (AMHC) conducted a program evaluation of a therapeutic wilderness family camp that had been facilitated at AMHC for more than ten years. In addition to utilizing a camping and adventure-based modality, Family-Directed Structural Therapy (FDST) was the helping model used during therapy sessions and served as a context for an adventure-based activity. FDST is a family-guided helping modality that includes an assessment tool that is completed by adult family members. As a result of indicators that FDST was a useful way for families and service providers to improve family functioning, FDST training was implemented in two Community Mental Health Centers (CMHCs) in FY 2006. For a complete report on the findings of the FY 2004 and 2005 program evaluation and a description of FDST, see the Children's Mental Health Task 11 FY 2004-2005 Final Report.

The goal of the FDST training project was three-fold. First, KU staff wanted to better understand if the FDST model could be taught to various service providers (including case managers, attendant care workers, parent support specialists, home-based family therapists, and out-patient therapists) and if these people could utilize the model in their work with families. Second, KU staff wanted to measure both service provider and family satisfaction with the model. Finally, it was hypothesized that FDST could provide a "common language" for participating service providers and families with whom they work, thus facilitating continuity of care, based on goals and areas of concern ***as defined by the family.***

The opportunity to participate in the FDST training project was offered to five CMHCs, based on pre-existing staffing structure that offered some level of integration between Children's Community Based Services (CBS) and out-patient services. Two CMHCs, Pawnee Mental Health Services (PMHS) and Johnson County Mental Health Center (JCMHC), were able undertake the project during FY 2006. Six hour FDST trainings were offered at both CMHCs, with the Manhattan CBS team attending at PMHS and the Mission CBS team attending at JCMHC. Self-selected out-patient therapists attended at both sites. While the six hour training was offered at the outset of the project, the training was offered throughout the year, to account for staff turn over and other needs of the CMHCs. An FDST Knowledge Assessment was administered before and after the six hour training and, consequently, it was demonstrated that FDST can be taught and understood within the context of this time frame.

KU staff were available for FDST supervision on a weekly basis at both CMHCs. As of June 15, 2006, KU FDST training staff had provided 72 hours of individual FDST supervision, 218.5 hours of group FDST supervision at both CMHCs combined.

Additionally, combining the two CMHCs, 20 service providers had been trained and 36 families of Seriously Emotionally Disturbed (SED) children had received FDST as of June 15, 2006.

FDST Supervisor Rating Scales and Service-Provider Self-Rate Scales verified that service providers can reach a level of proficiency sufficient for client utilization within four to six weeks, rather than the originally projected ninety-day time frame. As indicated by Service Providers Satisfaction Surveys, project participants' involvement in the training minimally interrupted regular service delivery, if at all.

Service providers reported the use of the FDST Assessment Tool facilitated better understanding and awareness of the family dynamics and "how the family sees the world". Participating staff reported the FDST model helped them to move away from a traditional diagnostic medical model, to a more systemic view of the family based both on strengths and areas of concern ***as defined by the family***. Finally, the FDST Assessment Tool provided a means by which to measure change in family functioning, as well as a way to address issues that may not have otherwise been identified.

The families who received FDST reported the model was helpful in identifying areas of concern and strengths. As documented in the Client Satisfaction Surveys, families thought the model was useful and they would recommend it to other families. They also indicated that the utilization of the model facilitated the inclusion of their opinions in the helping process. The Client Satisfaction Survey also documented that families had very little difficulty completing the Assessment Tool and had little, if any, difficulty with FDST terminology.

In summary, this training program demonstrated that the FDST model can be taught and utilized in CMHC settings, and that service providers and families endorse the model. The natural sequence from this point is to measure the functioning of families who receive FDST and compare them with families who do not receive the model. The upcoming year of the project includes expanded training and data collection making this comparison.

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Background

As a part of the FY 2004 and 2005 contracts, University of Kansas staff and Area Mental Health Center (AMHC) conducted an evaluation of a therapeutic wilderness family camping program facilitated by AMHC. In addition to adventure-based programming, the camps specifically utilized Family-Directed Structural Therapy (FDST) as a therapeutic modality. FDST is an approach to family therapy built on traditional concepts of Structural Family Therapy, Strengths Model, and Group Work Theory. It is a goal-oriented, time limited process that empowers the family through the identification of strengths and the provision of concrete skills via the use of a common vocabulary and a concretely organized, easily administered assessment tool that is completed by adult family members. Please see Appendix A for a description of FDST.

During these two years, data were collected to evaluate the efficacy of FDST as utilized in this family camp setting. Initial findings were promising in this non-traditional setting, thus for FY 2006, FDST was taken into a more conventional community mental health setting. For a complete report on the findings of the FY 2004 and 2005 program evaluation, see the Children's Mental Health Task 11 FY 2004-2005 Final Report.

During FY 2006, University of Kansas staff trained certain Children's Community Based Service (CBS) providers at Pawnee Mental Health Services (PMHS) and Johnson County Mental Health Center (JCMHC) in the use of FDST. KU staff facilitating this project consisted of the modality's creator, Don McLendon, and an FDST trained research assistant, Tara McLendon. Participating service providers then utilized FDST with selected families on their caseload. Finally, FDST staff completed supervision rating scales in regarding service provider proficiency with the tool and model; service providers completed surveys in reference to their proficiency in the use of the modality, as well as their satisfaction with the modality and project; and participating families completed project satisfaction surveys.

Goals and Population Served

This project was specifically designed to strengthen and enhance service delivery to seriously emotionally disturbed (SED) children and their families through use of a shared language and approach (FDST) by the CBS team, including the family, case managers, parent support specialists, case management assistants, in-home therapists, and attendant care workers, as well as out-patient clinicians.

Activities to Date

Pawnee Mental Health Services

A total of eighteen case managers, eight attendant care workers, three home-based family therapists, two parent support specialists, one behavioral health specialist, and one out-patient clinician were trained in the FDST model at three different six hour trainings (October 28, 2005; January 12, 2006; and June 2, 2006).

A sixteen question FDST Knowledge Assessment was given before and after both trainings in order to document knowledge gained by service providers during the six hour presentation.

- October Training
  - Mean pre-test score – 48.3%
    - Pre-test scores ranged from 7% to 86.7%
    - Median score of 50%
  - Mean post –test score - 81.8%
    - Post-test scores ranged from 46.7% to 100%
    - Median score of 80%
- January Training
  - Mean pre-test score - 41%
    - Pre-test scores ranged from 20% to 70%
    - Median score of 46.7%
  - Mean post-test score - 83.4%
    - Post-test scores ranged from 66.7% to 93.3%
    - Median score of 83.4%
- June Training
  - Mean pre-test score – 48.85%
    - Pre-test scores ranged from 13.3% to 66.6%
    - Median score of 53.3%
  - Mean post-test score – 80%
    - Post-test scores ranged from 73.3% to 86%
    - Median score of 80%

Weekly supervision was offered every Friday at both the out-patient office and CBS office. KU staff also attended CBS staffing, as well as CBS/out-patient staffing, held every Friday morning. **As of June 15, 2006, approximately 51 hours of individual supervision and 66.5 hours of group supervision had been provided.** This averaged to approximately 2 hours of individual supervision and 2.5 hours of group supervision per week. Following each session, KU staff completed a supervisor rating scale, which is a sixteen question survey that utilizes a five point Likert scale. This survey allowed KU staff to rate service providers' competence in utilizing the FDST assessment tool and modality. In order to begin utilizing the FDST Assessment Tool and modality with families, a score of at least "3" was required on each item of the supervisor rating scale.

As of June 15, 2006, fourteen service providers had been approved and twenty families had completed the FDST Assessment Tool at least once.

A. Service Provider Data Collection

Participating Pawnee service providers were asked to complete a nine question, five point Likert scale self-rate survey every 90 days. The purpose of this survey was to gain an understanding of service providers' own perceptions of their level of confidence and competence in the use of the FDST modality and assessment tool. As of June 15, 2006 fourteen service providers had completed this survey at least once. Ten respondents were case managers, two respondents were home-based family therapists, one was a parent support specialist, and one was an out-patient therapist. The results of the most recent collection are as follows:

I. Through FDST training and supervision, I have reached which level of knowledge of the following concepts:

Use the scale below to indicate level of knowledge:

1----------	2----------	3----------	4----------	5	NA
Beginning Knowledge		Moderate Knowledge		Advanced Knowledge	

- Core Issues
  - 0 service providers responded "1"
  - 1 service provider responded "2"
  - 3 service providers responded "3"
  - 8 service providers responded "4"
  - 2 service providers responded "5"

- Roles
  - 0 service providers responded "1"
  - 2 service providers responded "2"
  - 1 service provider responded "3"
  - 9 service providers responded "4"
  - 2 service providers responded "5"

- External Stressors
  - 0 service providers responded "1"
  - 1 service provider responded "2"
  - 1 service provider responded "3"
  - 9 service providers responded "4"
  - 3 service providers responded "5"

- Family Circle
  - 0 service providers responded "1"

- 1 service provider responded “2”
- 2 service providers responded “3”
- 9 service providers responded “4”
- 2 service providers responded “5”

- Framework of Interaction
  - 1 service provider responded “1”
  - 2 service providers responded “2”
  - 1 service provider responded “3”
  - 9 service providers responded “4”
  - 1 service provider responded “5”

II. Through FDST training and supervision, I have reached which level of competence in the following procedures.

Use the scale below to indicate level of competence:

1----------2----------3----------4----------5 NA

Beginning Competence	Moderate Competence	Advanced Competence

- Ability to explain, administer, and score the FDST Assessment Tool
  - 1 service provider responded “1”
  - 1 service provider responded “2”
  - 3 service providers responded “3”
  - 8 service providers responded “4”
  - 1 service provider responded “5”

- Ability to allow client(s) to identify areas of concern
  - 0 service providers responded “1”
  - 2 service providers responded “2”
  - 2 service providers responded “3”
  - 8 service providers responded “4”
  - 2 service providers responded “5”

- Ability to identify client strengths from the FDST Assessment Tool
  - 0 service providers responded “1”
  - 3 service providers responded “2”
  - 1 service provider responded “3”
  - 6 service providers responded “4”
  - 4 service providers responded “5”

- Ability to utilize team approach, via use of FDST modality and the “common language” it provides
  - 0 service providers responded “1”
  - 1 service provider responded “2”

- 5 service providers responded “3”
- 6 service providers responded “4”
- 2 service providers responded “5”

Service providers were also asked to complete a 14 question satisfaction survey once every 90 days. As of June 15, 2006 twelve service providers completed this survey at least once. Nine respondents were case managers, two were home-based family therapists, and one was an out-patient therapist. The results from the most recent collection are as follows:

- During the past 90 days, how many times have you administered the FDST Assessment Tool?
  - One service provider administered the tool 5-6 times
  - Three service providers administered the tool 3-4 times
  - Six service providers administered the tool 1-2 times
  - Two service providers had not administered the tool

- During the past 90 days, which of the following choices best describes your overall experience in the administration of the FDST Assessment Tool?
  - Three service providers responded “No difficulty”
  - Eight service providers responded “Minimal difficulty”
  - One service provider responded “Moderate difficulty”

- Core Issues were useful in identifying areas of strength and areas of concern.
  - Nine service providers responded “Most of the time”
  - Three service providers responded “More than half the time”

- The concept of Roles was helpful in identifying and establishing boundaries within the Family Circle.
  - Nine service providers responded “Most of the time”
  - Three service providers responded “More than half the time”

- External Stressors were useful in identifying strengths and areas of concern.
  - Ten service providers responded “Most of the time”
  - One service provider responded “More than half the time”
  - One service provider responded “Half the time”

- When working with families, the picture of the Family Circle was a useful tool in addressing roles and boundaries.
  - Twelve service providers responded “Yes”
  - No service providers responded “No”

- The scoring system for the FDST Assessment Tool was easy to utilize with and explain to your clients:
  - Eight service providers responded “Most of the time”

- Four service providers responded “More than half the time”

- The scoring system for the FDST Assessment Tool was easy for adult family members to understand and utilize.
  - Five service providers responded “Most of the time”
  - Seven service providers responded “More than half the time”

- The Framework of Interaction helped you to discuss ways in which the family might address areas of concern.
  - Eleven service providers responded “Most of the time”
  - One service provider responded “More than half the time”

- Utilizing FDST terminology was helpful in developing a common language between FDST service providers and their clients.
  - Six service providers responded “Most of the time”
  - Six service providers responded “More than half the time”

- The FDST model enhanced the involvement of adult family members in the treatment process.
  - Ten service providers responded “Most of the time”
  - One service provider responded “More than half the time”
  - One service provider responded “Half of the time”

- Supervisory staff addressed concerns and questions of service providers regarding FDST training and supervision.
  - Eleven service providers responded “All of the time”
  - One service provider responded “Most of the time”

- The weekly supervision sessions scheduled during the past 90 days have been constructive and helpful in facilitating the FDST learning process.
  - Ten service providers responded “All of the time”
  - Two service providers responded “Most of the time”

- The time required to participate in this project has interfered with my regular job responsibilities.
  - Seven service providers responded “None of the time”
  - Five service providers responded “Some of the time” (due to travel from satellite office to main office for supervision or due to job as an out-patient therapist with very high demands on time)

B. Family Data Collection

Finally, client satisfaction surveys were collected every 90 days from adult family members who participated in the project. As of June 15, 2006, the FDST Assessment Tool had been completed with twenty families. All families had been given satisfaction

surveys, and as of this date, fourteen individual adult surveys had been returned. The results of these surveys are as follows:

- Which service provider introduced the Family -Directed Structural Assessment Tool to you and your family?
    - Eight participants responded “Case Manager”
    - Four participants responded “Case Manager and Home-Based Family Therapist”
    - Two participants responded “Out-Patient Therapist”

- Which service providers have discussed the Family-Directed Structural Assessment Tool with you?
    - Eight participants responded “Case Manager”
    - Four participants responded “Case Manager and Home-Based Family Therapist”
    - Two participants responded “Out-Patient Therapist”

- I was able to understand the Family-Directed Structural Assessment Tool and complete it with:
    - Five participants responded “No difficulty”
    - Seven participants responded “Very little difficulty”
    - Two participants responded “Some difficulty”

- The Family-Directed Structural Assessment Tool was helpful to identify my family’s strengths and problems/areas of concern:
    - Four participants responded “Most of the time”
    - Eight participants responded “More than half the time”
    - Two participants responded “Half of the time”

- When discussing the Family-Directed Structural Assessment Tool with service providers, I was allowed to decide which problems/areas of concern needed addressed:
    - Seven participants responded “All of the time”
    - Seven participants responded “Most of the time”

- Service providers assisted the family in identifying strengths:
    - Seven participants responded “All of the time”
    - One participant responded “Most of the time”
    - Six participants responded “More than half the time’

- The picture of the Family-Directed Structural Family Circle was helpful to me.
    - All fourteen participants responded "Yes"
    - No participants responded "No"

- The terms and language used in the Family-Directed Structural Assessment Tool were helpful in talking about family problems/areas of concern with the service providers from the mental health center.

    - Ten participants responded "All of the time"
    - Four participants responded "Most of the time"

- The service providers from the mental health center appeared knowledgeable about the Family-Directed Structural Assessment Tool.

    - Eleven participants responded "All of the time"
    - Three participants responded "Most of the time"

- I would recommend the Family-Directed Structural Assessment Tool to other families who are receiving Community Mental Health Center services.

    - All fourteen participants responded "Yes"
    - No participants responded "No"

Diagnostic information, birth date, and sex were collected on the twenty SED children participating in the project. This demographic data are as follows:

- Sex
    - Eleven Boys
    - Nine Girls

- Mean age of 12.5 years
- Median age of 12
- Ages ranged from 8 to 19 years

- Primary Diagnosis
    - Attention-Deficit/Hyperactivity Disorder, Combined Type – 11
    - Bipolar Disorder – 3
    - Anxiety Disorder - 1
    - Post-Traumatic Stress Disorder – 1
    - Oppositional Defiant Disorder – 4

- Mean GAF of 55
- Median GAF of 55
- GAF scores ranged from 50 to 60

C. Fidelity Adherence

At both PMHS and JCMH, supervision sessions with service providers were audio-tape recorded, transcribed, and are currently being analyzed by two FDST trained social workers. Recordings are collected at least twice per month. The purpose of this component of the project is to document that the modality and assessment tool are the focus of supervision (treatment adherence), as well as to document the competence with which the service providers utilize the modality within the confines of supervision.

Johnson County Mental Health Center

A total of four case managers, eight out-patient therapists, three school-based therapists, two case management assistants, two home-based family therapists, and one parent support specialist were trained in the FDST model at two different six hour trainings (October 21, 2005 and December 12, 2005). A sixteen question FDST Knowledge Assessment was given before and after both six hour trainings in order to document knowledge gained by service providers during these presentations.

- October Training
  - Mean pre-test score – 50.6%
    - Pre-test scores ranged from 7% to 80%
    - Median score of 50%
  - Mean post –test score - 86%
    - Post-test scores ranged from 73.3% to 100%
    - Median score of 86.7%
- December Training
  - Mean pre-test score - 48%
    - Pre-test scores ranged from 7% to 86.7%
    - Median score of 53.3%
  - Mean post-test score - 84.4%
    - Post-test scores ranged from 60% to 100%
    - Median score of 86.7%

Weekly FDST supervision was offered the first, third, and fourth Tuesday of every month at the JCMHC Mission office. KU staff attended the Mission CBS Tuesday morning staffing, as well as being available for individual supervision throughout the day. On the second Monday of every month, KU staff attended Mission out-patient clinical team staffing from 9:30-10:00, as well as CBS staffing with their child psychiatrist from 10:00-11:00. Individual supervision was also offered throughout the day on the second Monday of the month. **As of June 15, 2006, approximately twenty-one hours of individual supervision and one hundred fifty-two hours of group supervision had been provided.** This averaged to approximately 0.8 hours of individual supervision and 5.8 hours of group supervision per week.

As at PMHS, following each supervision session with JCMHC staff, KU staff completed a supervisor rating scale, which is a sixteen question survey that utilizes a five point

Likert scale. This survey allowed KU staff to rate service providers' competence in utilizing the assessment tool and modality. In order to begin utilizing the assessment tool and modality with families, service providers had to obtain a score of at least "3" on each item of the supervisor rating scale. To date, six service providers have been approved and sixteen families have received FDST service.

A. Service Provider Data Collection

As at PMHS, participating JCMH service providers were asked to complete a nine question, five point Likert scale self-rate survey every 90 days. Again, the purpose of this survey was to gain an understanding of service providers' own perceptions of their level of confidence and competence in the use of the FDST modality and assessment tool. As of June 15, 2006 six service providers had completed this survey at least once. Four respondents were case managers, one respondent was a home-based family therapist, and one was an out-patient therapist. The results of the most recent collection are as follows:

I. Through FDST training and supervision, I have reached which level of knowledge of the following concepts:

Use the scale below to indicate level of knowledge:

1----------	2----------	3----------	4----------	5	NA
Beginning Knowledge		Moderate Knowledge		Advanced Knowledge	

- Core Issues
  - 0 service providers responded "1"
  - 0 service providers responded "2"
  - 1 service provider responded "3"
  - 4 service providers responded "4"
  - 1 service provider responded "5"

- Roles
  - 0 service providers responded "1"
  - 0 service providers responded "2"
  - 2 service providers responded "3"
  - 3 service providers responded "4"
  - 1 service provider responded "5"

- External Stressors
  - 0 service providers responded "1"
  - 0 service providers responded "2"
  - 2 service providers responded "3"
  - 3 service providers responded "4"
  - 1 service provider responded "5"

- Family Circle
  - 0 service providers responded “1”
  - 0 service providers responded “2”
  - 2 service providers responded “3”
  - 3 service providers responded “4”
  - 1 service provider responded “5”

- Framework of Interaction
  - 0 service providers responded “1”
  - 0 service providers responded “2”
  - 2 service providers responded “3”
  - 4 service providers responded “4”
  - 0 service providers responded “5”

II. Through FDST training and supervision, I have reached which level of competence in the following procedures.

Use the scale below to indicate level of competence:

1----------2----------3----------4----------5 NA

Beginning Competence	Moderate Competence	Advanced Competence

- Ability to explain, administer, and score the FDST Assessment Tool
  - 0 service providers responded “1”
  - 0 service providers responded “2”
  - 1 service provider responded “3”
  - 2 service providers responded “4”
  - 3 service providers responded “5”

- Ability to allow client(s) to identify areas of concern
  - 0 service providers responded “1”
  - 0 service providers responded “2”
  - 2 service providers responded “3”
  - 1 service provider responded “4”
  - 3 service providers responded “5”

- Ability to identify client strengths from the FDST Assessment Tool
  - 0 service providers responded “1”
  - 0 service providers responded “2”
  - 2 service providers responded “3”
  - 1 service provider responded “4”
  - 3 service providers responded “5”

- Ability to utilize team approach, via use of FDST modality and the "common language" it provides
    - 0 service providers responded "1"
    - 0 service providers responded "2"
    - 0 service providers responded "3"
    - 3 service providers responded "4"
    - 3 service providers responded "5"

Service providers were also asked to complete a 14 question satisfaction survey once every 90 days. As of June 15, 2006 six service providers completed this survey at least once. Four respondents were case managers, one was a home-based family therapist, and one was an out-patient therapist. The results from the most recent collection are as follows:

- During the past 90 days, how many times have you administered the FDST Assessment Tool?
    - One service provider administered the tool 3-4 times
    - Five service providers administered the tool 1-2 times

- During the past 90 days, which of the following choices best describes your overall experience in the administration of the FDST Assessment Tool?
    - One service provider responded "No difficulty"
    - Five service providers responded "Minimal difficulty"

- Core Issues were useful in identifying areas of strength and areas of concern.
    - Five service providers responded "Most of the time"
    - One service provider responded "More than half the time"

- The concept of Roles was helpful in identifying and establishing boundaries within the Family Circle.
    - Four service providers responded "Most of the time"
    - Two service providers responded "More than half the time"

- External Stressors were useful in identifying strengths and areas of concern.
    - Five service providers responded "Most of the time"
    - One service provider responded "More than half the time"

- When working with families, the picture of the Family Circle was a useful tool in addressing roles and boundaries.
    - Six service providers responded "Yes"
    - No service providers responded "No"

- The scoring system for the FDST Assessment Tool was easy to utilize with and explain to your clients:

    - Four service providers responded “Most of the time”
    - One service provider responded “More than half the time”
    - One service provider responded “Half of the time”

- The scoring system for the FDST Assessment Tool was easy for adult family members to understand and utilize.

    - Two service providers responded “Most of the time”
    - Three service providers responded “More than half the time”
    - One service provider responded “Half of the time”

- The Framework of Interaction helped you to discuss ways in which the family might address areas of concern.

    - Four service providers responded “Most of the time”
    - Two service providers responded “More than half the time”

- Utilizing FDST terminology was helpful in developing a common language between FDST service providers and their clients.

    - Three service providers responded “Most of the time”
    - Two service providers responded “More than half the time”
    - One service provider responded “Half of the time”

- The FDST model enhanced the involvement of adult family members in the treatment process.

    - Three service providers responded “Most of the time”
    - Three service providers responded “More than half the time”

- Supervisory staff addressed concerns and questions of service providers regarding FDST training and supervision.

    - Three service providers responded “All of the time”
    - Three service providers responded “Most of the time”

- The weekly supervision sessions scheduled during the past 90 days have been constructive and helpful in facilitating the FDST learning process.

    - Three service providers responded “All of the time”
    - Three service providers responded “Most of the time”

- The time required to participate in this project has interfered with my regular job responsibilities.

    - Three service providers responded “None of the time”
    - Three service providers responded “Some of the time”

B. Family Data Collection

As at PMHS, client satisfaction surveys were collected every 90 days from JCMH adult family members who participated in the project. As of June 15, 2006, the assessment tool had been completed at least once with sixteen families. All families were given satisfaction surveys, and as of this date, eighteen individual adult surveys were returned. The results of this survey are as follows:

- Which service provider(s) introduced the Family-Directed Structural Assessment Tool to you and your family?

    - Eight participants responded “Case Manager”
    - Six participants responded “Home-Based Family Therapist”
    - Three participants responded “Out-Patient Therapist and Case Manager”
    - One participant responded “Out-Patient Therapist”

- Which service provider(s) have discussed the Family-Directed Structural Assessment Tool with you?

    - Six participants responded “Case Manager”
    - Six participants responded “Out-Patient Therapist and Case Manager”
    - Three participants responded “Out-Patient Therapist, Home-Based Family Therapist, Case Manager, and Parent Support Specialist”
    - Two participants responded “Home-Based Family Therapist”
    - One participant responded “Out-Patient Therapist”

- I was able to understand the Family-Directed Structural Assessment Tool and complete it with:

    - Four participants responded “No difficulty”
    - Ten participants responded “Very little difficulty”
    - Four participants responded “Some difficulty”

- The Family-Directed Structural Assessment Tool was helpful to identify my family’s strengths and problems/areas of concern:

    - Nine participants responded “Most of the time”
    - Six participants responded “More than half the time”

    - Three participants responded “Half the time”

- When discussing the Family-Directed Structural Assessment Tool with service providers, I was allowed to decide which problems/areas of concern needed addressed:

    - Thirteen participants responded “All of the time”
    - Five participants responded “Most of the time”

- Service providers assisted the family in identifying strengths:

    - Eleven participants responded “All of the time”
    - Six participants responded “Most of the time”
    - One participant responded “Some of the time”

- The picture of the Family-Directed Structural Family Circle was helpful to me.

    - Sixteen participants responded “Yes”
    - Two participants responded “No”

- The terms and language used in the Family-Directed Structural Assessment Tool were helpful in talking about family problems/areas of concern with the service providers from the mental health center.

    - Ten participants responded “All of the time”
    - Six participants responded “Most of the time”
    - Two participants responded “Some of the time”

- The service providers from the mental health center appeared knowledgeable about the Family-Directed Structural Assessment Tool.

    - Fourteen participants responded “All of the time”
    - Four participants responded “Most of the time”

- I would recommend Family Directed Structural Therapy to other families who are receiving Community Mental Health Center services.

    - Seventeen participants responded “Yes”
    - One participant responded “No”

As of June 15, 2006 diagnostic information, birth date, and sex were collected on the fifteen of the nineteen SED children participating in the project. These data are as follows:

- Sex
    - Twelve Boys
    - Three Girls

- Mean age of 10.9 years
- Median age of 11
- Ages ranged from 6 to 16 years

- Primary Diagnosis
    - Attention-Deficit/Hyperactivity Disorder, Combined Type – 11
    - Bipolar Disorder – 2
    - Anxiety Disorder - 1
    - Depression – 1

- Mean GAF of 51
- Median GAF of 54
- GAF scores ranged from 30 to 65

Interviews with CMHC staff and administrators

As part of the evaluation of the training and supervision, Dr. Chris Petr, Principal Investigator for this project, conducted interviews with trained staff (therapists, case managers, attendant care workers) and with administrators (team leaders, CBS Directors, clinical directors) at both PMHS and JCMHC. The purpose of these interviews was to learn more about how the FDST model was received and utilized, and what suggestions CMHC staff had for improvement.

Strengths of the model and the training/supervision provided: Overall, both administrators and trained staff were very positive about the FDST model and the training and supervision received. They were eager to begin the next phase (Phase Two) of the project, which involves training of additional staff and collection of outcome data from families who receive FDST (although JCMHC must postpone additional training).

The model was useful in providing the team and the families with a common language to discuss family issues. Workers found that the structure and vocabulary of the FDST enabled them to quickly assess and discuss areas of concern, often about serious topics and issues that probably would not have been broached otherwise. The core issues and the rules of engagement were particularly useful to the work, and even young children seemed to be able to grasp the essential meaning of the constructs. They rated the training sessions as excellent, with appropriate slides, examples, and discussion—no suggestions for improvement in the training were made. The supervision sessions were also helpful, and they appreciated the flexibility of the KU staff in scheduling appointments and being available.

Issues for Phase Two: Three issues were identified as needing attention prior to full implementation of Phase 2, of which one component is outcome evaluation of the

effectiveness of the model. For evaluation purposes, it will be important to develop some uniformity in the responses to these issues so that families receive the same implementation of FDST.

1. *Using FDST from the beginning of service*

To date, all of the families with whom FDST has been utilized have been existing clients, not new clients, as will be the case in Phase 2. Some staff indicated there may need to be some time for relationship building before the FDST assessment tool is introduced, so that the chances of client acceptance and honesty could be maximized.

Recommendation: Begin the FDST assessment at either the first, second, or third meeting with assigned service provider, depending on clinical judgment of the provider. It is anticipated that the majority will be completed at the second session.

2. *Integrating children more fully into the process*

Most respondents felt that children could readily understand and utilize FDST vocabulary, especially the core issues and rules of engagement. It would be helpful, however, to have some guidelines about how to integrate children more fully into the process, and to clarify the role of the attendant care worker (case manager assistant) and case manager in this process. Generally, respondents thought that children probably should not be present with parents at the initial administration of the assessment tool, so that the parents could be less inhibited in their responses, but that they should be included at times in later family sessions, as well as use the terminology in their individual meetings. Some also wondered if it was counterproductive to educate children about the language if the parents are not participating in the project.

Recommendation: Develop guidelines for participation and involvement of children.

3. *Clarifying criteria and roles for "full" as compared to "partial" implementation of the FDST model*

Most service providers agreed that the "best" or "ideal" situation is for both a case manager and an in-home (or outpatient) family therapist to be involved with a family regarding implementation of the model. This represents "full" implementation of the model, and staff are comfortable with their respective roles in this situation.

A "partial" level of implementation exists when the case manager implements the FDST model without benefit of a therapist. This is a "partial" level because the family receives less than the ideal situation. Under this condition, case managers are faced with two types of related challenges: First, case managers are not clear about their role and about what activities constitute case management and what constitute therapy. Conscious of not wanting to cross the line into therapy, they are not clear about what they are sanctioned to do, nor necessarily confident about doing it "alone".

Second, when they are implementing FDST "alone", they find that they need to spend much more time with their FDST families than those cases in which they do not implement FDST. For the latter cases, they typically are more child focused and interact with parents in more of a consultative, "parent conference" sort of way, discussing the progress of the child. When they implement FDST, they want to, and/or feel they should, spend more time with the parents, but not at the expense of their time with the children. Hence, FDST cases are more complex and time consuming.

Recommendations: This situation has important and critical implications for the outcome evaluation. First, it is important to establish procedures (both clinical and administrative) that maximize the number of participants in the "full" implementation group. That is, maximize the potential to document the effectiveness of FDST when it is fully or ideally implemented. Second, outcomes will need to be tracked for the "case management only" group, separate from the "full" group, to compare results. A hypothesis will also need to be made regarding the effectiveness of partial implementation versus full implementation. Complicating factors here include controlling for severity and other variables across the two subgroups.

Third, it is vitally important to establish the parameters of the "partial" implementation subgroup (case management only). Case managers and administrators need to feel comfortable with the role and intensity of case management only implementation. These guidelines would also help to standardize the intervention across individual case managers. At a minimum, these guidelines should address the expected frequency of FDST contact, as well as how the nature of case management only implementation activities are similar to and different from therapist implementation.

Conclusion

The first year of the FDST training program provided a unique opportunity to provide ongoing training in two CMHCs. The administration and supervisory staff at both facilities were supportive of the training program throughout the year. Service providers who participated were receptive to the training process and the utilization of new tools and concepts. All levels of administration and service providers were instrumental to the success which the training project experienced. Feedback and suggestions made by participating service provider and administrators will be seriously considered, shaping and influencing the second year of the project.

While the same basic project design was utilized at both CMHCs, geographic and structural differences made the implementation of the project vary somewhat. The two CMHCs, Pawnee Mental Health Services (PMHS) and Johnson County Mental Health Center (JCMHC), differ in that PMHS is in a rural area, while JCMHC is in an urban setting. At PMHS, this necessitated that some service providers drive up to an hour to the Manhattan office to attend FDST supervision. By virtue of pre-existing CBS team structures at each CMHC, a larger group of service providers was trained at PMHS than

at JCMHC. Finally, more out-patient service providers chose to attend the six-hour training at JCMHC than at PMHS.

As documented in the FDST Knowledge Assessment, it was demonstrated that FDST can be taught and understood in one six-hour training. Furthermore, FDST Supervisor Rating Scales and Service-Provider Self-Rate Scales verified that service providers can reach a level of proficiency sufficient for client utilization within four to six weeks, rather than the originally projected ninety-day time frame. As indicated by Service Providers Satisfaction Surveys, project participants' involvement in the training minimally interrupted regular service delivery, if at all.

During the process of the training project, the flexibility of the model was demonstrated. FDST core issues (commitment, credibility, empowerment, control of self, and consistency) and components of the framework of interaction (specifically "Rules of Engagement" and "60/40 Rule") were utilized outside of the context of the Assessment Tool. Specific examples are as follows:

- One out-patient therapist utilized the core issues in an adolescent girls' group as a context for problem solving;
- Four school-based service providers used the core issues in classroom groups in a similar manner;
- Three of these service providers had the groups draw pictures of themselves utilizing the core issues in daily life, and one provided KU staff with a picture drawn by an unidentified five-year old. The picture showed the child "using control of self" by sitting on the school bus with his/her hands folded;
- Two service providers reported school personnel utilizing FDST terms, after having been introduced to the model by the respective service providers.

Service providers reported the use of the FDST Assessment Tool facilitated better understanding and awareness of the family dynamics and "how the family sees the world". Participating staff reported the FDST model helped them to move away from a traditional diagnostic medical model, to a more systemic view of the family based both on strengths and areas of concern ***as defined by the family***. Finally, the Assessment Tool provided a means by which to measure change in family functioning, as well as a way to address issues that may not have otherwise been identified.

The families who received FDST reported the model was helpful in identifying areas of concern and strengths. As documented in the Client Satisfaction Surveys, families thought the model was useful and they would recommend it to other families. They also indicated that the utilization of the model facilitated the inclusion of their opinions in the helping process. The Client Satisfaction Survey also documented that families had very little difficulty completing the Assessment Tool and had little, if any, difficulty with FDST terminology.

Some barriers were encountered in the implementation of FDST in both CMHCs. Current Medicaid regulations stipulate that family therapy be provided with the child present. This presents a limitation to the delivery of family therapy in that there are frequently

situations in which parents need to discuss issues with the service providers, and it is not appropriate for the child or children to be present. Specifically, in FDST, the parent(s) are seen as the fulcrum of power and source of change. This dynamic necessitates that the parents identify and prioritize areas of concern, discuss how these issues will be addressed, and then the children are brought into the helping process. Within the context of current federal regulations, this process cannot be easily facilitated.

While the CBS staff supported implementation of the FDST model, there was less endorsement from out-patient staff. Out-patient staff utilized the model to some degree, however, there was more emphasis on the use of models used prior to the introduction of FDST. This factor, along with minimal or no formal interaction or communication between CBS and out-patient staff, precluded the complete implementation of a "shared language" between CBS and out-patient staff via the utilization of FDST. Including the FDST Assessment Tool as a part of the intake process and as a part of the treatment plan could be a way to improve consistent utilization by the entire treatment staff.

There are also a limited number of home-based family therapists, which limits the number of families that can receive this service. Another barrier to service provision, home-based or office-based, is the large amount of client cancelled or missed appointments. This dynamic limited the continuity with which FDST (or any other helping modality) could be implemented.

This training program demonstrated that the FDST model can be taught and utilized in CMHC settings, and that service providers and families endorse the model. The natural sequence from this point is to measure the functioning of families who receive FDST and compare them with families who do not receive the model. The upcoming year of the project includes expanded training and data collection making this comparison.