

**Children's Mental Health Task 11 FY 2007:
Family-Directed Structural Therapy Training
and Outcome Measures Project
Year End Report**

July 2007

**This report was completed under the Title XIX Children's Mental Health Contract
between Kansas Social Rehabilitation Services and The University of Kansas School
of Social Welfare.**

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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. For a complete report on the findings of the FY 2006 project, see the Children's Mental Health Task 11 FY 2006 Final Report.

During FY 2007, KU staff continued to provide training to new CBS staff at these CMHCs, offered regular supervision to service providers already trained in the model, as well as collecting outcome data from families with whom FDST was being utilized. At PMHS, this included continuing to supervise and train staff at the Manhattan CBS office. In addition, Junction City CBS staff were trained and supervision was offered every other week (the same frequency with which staff meetings are held). At JCMHC, new Mission CBS staff were trained and supervision was offered on a weekly basis. At PMHS and JCMHC, outcome data were also collected from certain CBS families who received only usual CMHC services and did not receive FDST. The purpose of this was to compare outcomes of families who received FDST with families who did not, in order to better

understand the effectiveness of FDST. CBS families at the PMHS Concordia office and the JCMHC Olathe office served in this capacity.

Goals and Population Served

This project was specifically designed to better understand the effectiveness of FDST and 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, home-based family therapists, and attendant care workers.

Activities to Date

Pawnee Mental Health Services

As of July 1, 2007, 53 additional staff members have received formal FDST training (in addition to staff trained in FY 2006). This includes 31 additional case managers, 12 attendant care workers, four home-based family therapists, three parent support workers, one outpatient therapist, and two team leaders. During FY 2007, training was expanded from one day to two days. The two day trainings allows for more extensive discussion regarding scoring, as this is one of the more complex aspects of this helping modality. Additionally, a draft of an FDST training manual has been developed and utilized in this training. This manual will continue to be expanded and developed during FY 2008. It includes a specific protocol regarding inclusion of children, use of FDST in crisis situations, and guidance for scoring and helping families to understand and utilize their scores.

At both PMHS and JCMHC, family outcome data is being collected at baseline (when families enter the CBS system), three months post baseline, and six months post baseline. For treatment families, data collected at these intervals include the FDST assessment tool and the Family Adaptability and Cohesion Evaluation Scale II (FACES II). The Child Behavior Checklist (CBCL) is also being collected. CBCLs collected every six months as a part of CBS service provision are utilized for this purpose. As of July 1, 2007, six families had completed baseline data, five families had completed baseline and three month post baseline data, and three families had completed baseline, three month post baseline data, and six month post baseline data. For comparison families, the FACES II is being collected at baseline, three months post baseline, and six months post baseline. CBCLs are being collected in a manner consistent with treatment families. As of July 1, 2007, three comparison families had completed baseline data, three families had completed baseline and 3 month post baseline data, and eight families had completed baseline, 3 month post baseline data, and 6 month post baseline data.

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. 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

As of July 1, 2007, three additional case managers and one additional parent support worker have received formal FDST training. The numbers for JCMHC vary significantly from PMHS because JCMHC did not have an additional CBS team trained, and the numbers for JCMHC represent staff turnover in the CBS team trained in FY 2006 that necessitated FDST training for new service providers. Supervision has also been offered on a regular basis. The data collection schedule is identical to the protocol at PMHS. As of July 1, 2007, four treatment families had completed baseline data, two treatment families had completed baseline and three month post baseline data, and three treatment families had completed baseline, three month post baseline data, and six month post baseline data. As of July 1, 2007, four comparison families had completed baseline data, seven comparison families had completed baseline and three month post baseline data, and one family had completed baseline, three month post baseline, and six month post baseline data.

Activities Remaining to Fulfill FY 2007 Contract

New families were accepted into the study through June 30, 2007 at PMHS and through April 30, 2007 at JCMHC. Because data collection lasts six months, this process will continue through December 2007 at PMHS and October 2007 at JCMHC. When this process is complete, data analysis will take place, and a report will be submitted to the state and made available to other interested parties.

Activities for FY 2008 Contract

As mentioned above, data collection will continue into FY 2008 and data analysis will take place early in 2008. In addition to these activities, a qualitative inquiry will be undertaken to better understand families' perception of FDST, its interface with CBS programming, and how these factors influence the family's change process. The purpose of this would be to identify ways improve training and the FDST model, as well as better understanding the change process. Families will be recruited from the pool of families who recently completed participation in the FDST outcome study. These interviews are planned to take place in the first part of the fiscal year. Data analysis will be completed and results will be disseminated during FY 2008.

Additional FDST training and supervision will be conducted for CBS teams at Concordia and Olathe, which served as comparison sites during FY 2007. In addition, the remainder of the CBS teams at JCMHC will receive training and supervision. This includes the Gardner/Edgerton, Step Ahead, Blue Valley, and DeSoto teams. Training will include the new two day format and the use of the FDST training manual. In addition, each team will have an on-site coordinator. This person will be an existing team member who will receive additional FDST training and be available to answer day-to-day questions

regarding the utilization of FDST. KU FDST staff will visit each site on a regular basis to provide supervision. The two day training will be available throughout the year to accommodate new staff members.

Conclusion

Continued training, supervision, and the addition of outcome data collection during FY 2007 provided a unique opportunity to continue provide a well-received training and supervision service to two CMHCs, as well as to continue to build a research base to aid in better understanding FDST and its application in a CMHC setting. Administration, supervisory staff, and service providers were supportive of the project throughout the year. As of July 1, 2007, outcome data had been collected for twenty-five treatment families and twenty-six comparison families. When data analysis is complete, it will provide outcome data on over 50 families served by CBS programming in Kansas. Moreover, it will compare the provision of usual services to an innovative model of service provision which includes utilizing FDST in addition to usual services.

The next phase of the project includes a qualitative study designed to better understand family perspectives of the FDST model, which will help to improve and refine the FDST model. Training will be also expanded to seven new teams and supervision will be provided throughout the year.

Appendix A

FDST is a structured helping modality that moves beyond the pathological and constrictive conceptualization of a diagnostic profile. Instead, it is a goal-oriented process that empowers the family through identification of strengths and the provision of concrete skills and is designed to be utilized by the family both inside and outside the clinical setting. It is built upon traditional concepts of Structural Family Therapy, The Strengths Model, and Group Work Theory.

In FDST, three conceptual areas (core issues, roles, and external stressors) are rated by adult family members utilizing the FDST assessment tool. The conceptual areas are rated on a scale of 1-4 (1=positive, 2=more positive than negative, 3=more negative than positive, and 4=negative). These scores are then used by the service provider and family to identify strengths and areas of concern.

In FDST, core issues are the fabric of family functioning and consist of commitment, credibility, empowerment, control of self, and consistency. Each adult rates themselves on these issues, as well rating their perception of their partner's core issues. First, commitment is the willingness to see situations through, despite difficulties and conflicts. Credibility is communicating what one will or will not do and demonstrating the ability to carry that through. Empowerment is having a sense that one's individual opinions are valued and respected, and believing one can affect change. Control of self is making a conscious change in unproductive behavior that results in reduced conflict and improved relationships. Finally, there is consistency, which is defined as behaviors and communications that are predictable and create a sense of safety within the family unit.

The roles scored and examined in FDST are: husband/partner, wife/partner, individual, parent, father, mother, and child(ren). The roles of husband/partner and wife/partner are defined as the intimate adult relationship between the husband and wife or partners, exclusive of the parent, mother, and father roles. The individual role encompasses the wants and needs of an individual, separate from all other roles. The parent role is defined as the relationship between the adult partners in the family that creates a parental unit and includes their ability to address the health, welfare, and educational needs of the child(ren). In a single parent family, the parent role is conceptualized in the same manner – the ability of that person to meet the health, welfare, and educational needs of his/her child(ren). Mother and father roles are the respective individual relationships with the child(ren), exclusive of the parent role. Finally, the child(ren) role encompasses how well the child(ren) function and how they interact with other people in the family.

External stressors are dynamics that impact the family from outside the basic internal structure. The effects of these stressors may be positive and supportive or negative and destructive. These dynamics include: “ex-relationships” (includes ex-spouses, ex-in-laws, ex-significant others), in-laws, parents, grandparents, employment, living conditions, finances, religious/spiritual, legal concerns, social service involvement,

hobbies and interests, school and extra-curricular activities, friends, alcohol and drugs, health care/medical, and “other”.

Finally, there is a framework of interaction that guides interaction and expectation among family members. The framework of interaction is comprised of suggested ideas and techniques to aid the family in discussing role identification, boundary clarification, and addressing external stressors and areas of concern.