Family Centered Treatment: Cultivating Hope Through Innovation

Family Centered Treatment Foundation Executive Leadership Team

Tim Wood, LCMHC, Executive Director
Janet Fuller-Holden, Operations Director
Melonie Sullivan, PhD, Director of Research and Program Evaluation
Jon McDuffie, LCSW, Implementation Director
Stephanie Glickman, LCSW, CCTP, Clinical Director

Table of Contents

Part 1: Understanding Family Centered Treatment

Executive Summary

In the three decades since its humble beginnings, the Family Centered Treatment (FCT) model and its practitioners have had the privilege of working with families across the United States. They have done so with the inherent understanding that families are better when they remain together. This year will mark a special anniversary for the not-for-profit Family Centered Treatment Foundation (FCTF) and the FCT model, as we will celebrate 30 years of service for families.

Since the late 1980's, FCT has had a positive impact on more than 40,000 families. Solutions for today's social challenges are complex. Through continuous innovation, while remaining true to its emphasis on finding practical solutions, the FCT model remains a national leader in helping families make meaningful changes. Throughout its history, FCT has consistently demonstrated positive outcomes as a family stabilization and reunification model of home-based trauma treatment.

Historically and through present day, 9 out of 10 families that participate in FCT achieve a successful outcome. Likewise, 98% of families that complete all phases of treatment achieve successful outcomes. In addition, more than 90% of families referred for services are engaged into treatment and 9 out of 10 families that receive FCT report that the FCT model has made a positive impact in their lives.

In the last decade, empirical research has demonstrated statistically significant positive results for individuals and families in treatment and post treatment. Peer reviewed studies have also demonstrated that the FCT model has saved state taxpayers millions of dollars by utilizing the service over a relatively short period of time.

Critical to the FCT model's success has been a rigorous yet provider-affordable implementation process for replicating FCT outcomes and validating model fidelity across sites and locations. FCTF has incorporated a unique best-practice implementation process that allows prospective and current licensed FCT providers to identify and plan for how they can go from initial to sustainable implementation. It is noteworthy that SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) cited the FCT model as having a 4.0 out of 4.0 Implementation Process in their independent review.

The FCT model has a diverse and growing body of recognition. FCT is recognized as an EBP by prominent National Clearinghouses including SAMHSA's National Childhood Traumatic Stress Network, The Title IV-E Prevention Services Clearinghouse and the California Evidence-based Clearinghouse for Child Welfare among others. In 2022, the FCT model's efficacy was published in peer-review publication for a third time. This adds to a growing number of experimental research studies and government reports.

On behalf of the FCT Foundation and its Board of Directors we are proud to present this 2022 White Paper. The future of the FCT model remains bright and is poised to make a continued positive impact on societal challenges and to aid in positive family functioning that is sustainable.

Timothy J. Wood, LCMHC
Timothy J. Wood - Executive Director, FCT Foundation, Inc.

Part 1: Understanding Family Centered Treatment

## What is Family Centered Treatment?

Family Centered Treatment (FCT) is a well-supported in-home trauma-focused family therapy model designed to find simple, practical and holistic solutions for families faced with disruption or dissolution of their family. This may be due to external and/or internal stressors, circumstances, or forced removal of their children from the home due to youths' delinquent behaviors or parents' harmful behaviors. The focus is to either strengthen and preserve children within their home or to bridge by successful reunification back into the home.

Unlike many theory-based treatments, FCT has been developed by practitioners over a 30-year period. It has been refined based on research, experience, and evidence of effectiveness derived from practice. Family response and feedback has been integral for defining what components of treatment have been effective and to meet the needs of the current social climate.

A foundational belief influencing the development of FCT is that the recipients of service have tremendous internal strengths and resources. This core value is demonstrated via the use of personalized family goals that are developed from strengths as opposed to deficits. Obtaining high engagement rates is a primary goal of FCT. The program is provided with families of specialty populations of all ages involved with agencies such as child welfare, mental health, substance abuse, developmental disabilities, juvenile justice and crossover youth.

The goals of Family Centered Treatment are:

• Enable family stability via stabilization of placement within the home or reunification back into the home.

• Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution.

• Reduce hurtful and harmful behaviors affecting family functioning by experientially practicing new behavioral interactions and learning the underlying function of the behaviors.

• Develop an emotional and functional balance in the family so the family system can cope effectively with any individual member's intrinsic or unresolvable challenges.

• Enable changes in the person referred's presenting behaviors to include family system involvement so families gain ownership of the changes and are not dependent upon the FCT practitioner.

• Enable discovery and effective use of the intrinsic strengths necessary for sustaining change and upholding stability.

• Incorporate generational and systemic influences of trauma on the family and address them from a systemic lens as opposed to an individual focus.
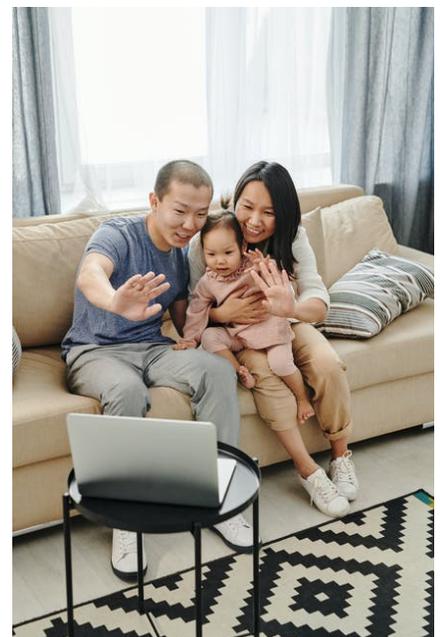
Part 1: Understanding Family Centered Treatment

History of Family Centered Treatment

Family Centered Treatment's origins derive from practitioners' efforts to find simple, practical and common-sense solutions for families faced with:

1) removal of the children from the home, or
2) dissolution of the family due to external or internal stressors and circumstances.

A distinguished practice grew out of a desire and mission to create opportunity for change for families that were seemingly stuck in a downward spiral. The approach used was both distinct yet grounded in the use of treatment components that were sound and research based. FCT did not begin in a university with a theoretical hypothesis, but rather grew daily as practitioners in the field had to devise options for difficult situations in the life space of their client families.

From its beginnings in the late 1980's and the formation of the FCT Foundation, the early practice of what would become FCT proved highly effective. One of the main reasons FCT has become applicable to so many populations is that only the most challenging cases were referred at its onset. At that time, funding was only available for youth facing imminent out-of-home placement. These youth were to be placed in institutional settings such as juvenile detention centers, psychiatric hospitals and residential treatment facilities. The FCT model founders, including co-founder John Sullivan, PhD, sought to bring concepts and tenets of practice that were successful in working with youth in residential facilities and apply them to the home and community.

These tenets emphasized expecting and demanding greatness while modeling dignity and respect. Practical skills and useful guidance were essential to forming a partnership with the families. The model evolved and was continually adapted for maximum impact in a family's home environment. This family-centered belief led to the founding of a non-traditional service agency whose foundation was based on this approach.

The first referrals were from the juvenile justice system. These were soon followed by social services and mental health agencies. By the early 1990's, FCT spread by word of mouth to multiple states. After a featured spot on the CBS news program "Eye on America" with Dan Rather, more agencies and locations became eager to try it. Reports and studies about success with families historically defined as 'resistant to services' resulted in continued growth.

Emphasis on mission—not profit—meant that resources were directed toward improving internal operations of the model and thus improving the practice. To date, Family Centered Treatment has spread to 75 sites across 11 states and continues to grow.

Components of the Model

The core practice components required by practitioners of Family Centered Treatment have evolved dramatically since the inception of the model in the 1980's. This has occurred because the key components of the model have been developed or integrated as frontline practitioners' experiences precipitated integral changes or additions.

Unique to FCT are the elements of transitional indicators into the four phases of treatment. Unlike many treatment processes that strictly rely on timeframes to determine when a family 'should' move to another phase of treatment, FCT utilizes its clinical supervision process to determine specific indicators demonstrating that a family has successfully completed a phase of treatment. This process is documented as part of the fidelity to the FCT model and indicated by the families' progress while guided by the practitioner, NOT strictly relying on number of days or sessions. An average duration of treatment approximates 6 months yet varies based on each family's unique circumstance.
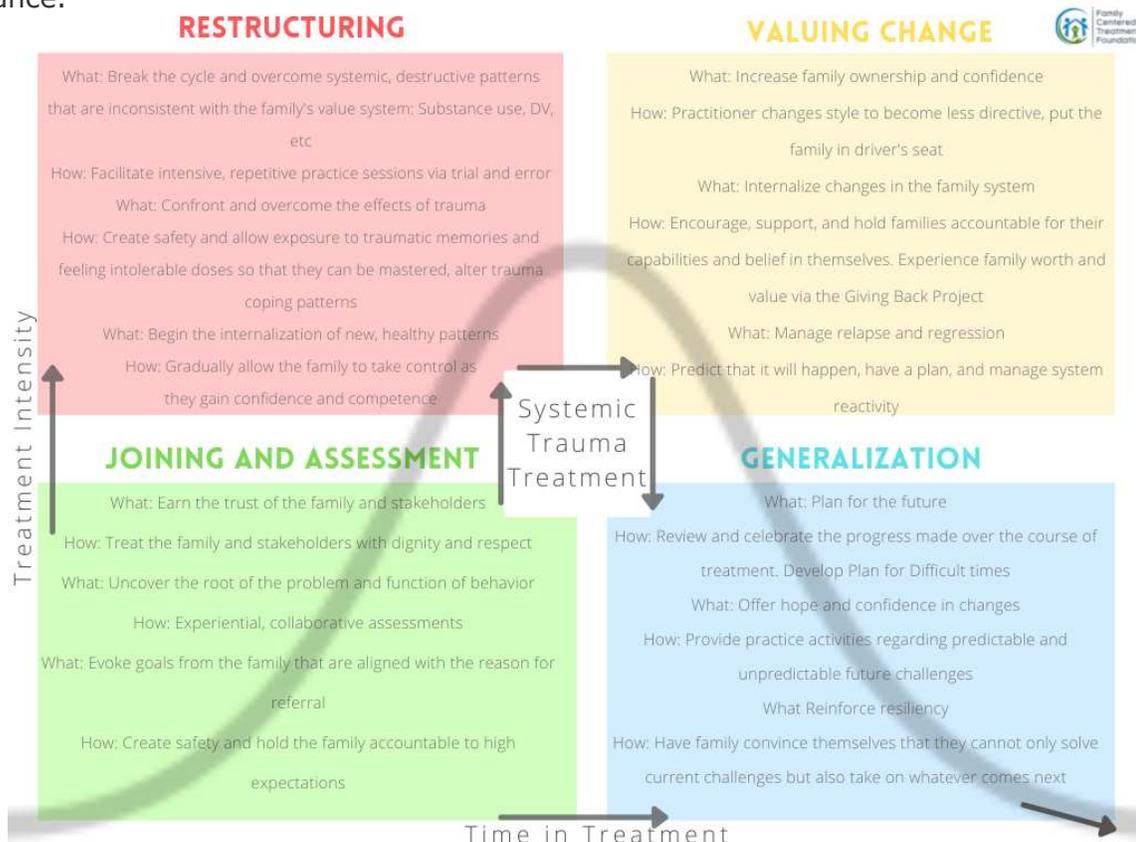
Part 2: The Family Centered Treatment Model

Components of the Model
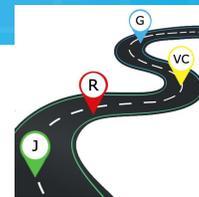
Joining and Assessment Phase

The Joining and Assessment Phase of FCT contains distinctive features. FCT practitioners respond quickly to referrals; the very nature of a referral indicates that a family is in acute crisis and the family needs immediate support. Timely response provides opportunity for engaging the family when they are more likely to be motivated to examine and change behaviors.

The Family Centered Evaluation© (FCE), comprised of specific instruments and trauma assessments, is completed with the family to identify needed additions, changes, or improvements in family functioning skills. Additionally, these FCE instruments are experiential, explore family resiliency, incorporate cultural and systemic influences, and evaluate generational patterns. The Family Assessment Device* and the Care Process Model-Pediatric Trauma Screener** are assessment tools incorporated into the model at initial, intermediate, and completion intervals. The FCE tools are designed to elicit family and individual feedback, and are administered by practitioners who are trained to determine if individual's or a family's traumas are creating emotional blocks for the family, thereby hindering them from functioning optimally. FCT practitioners are trained to screen for trauma in all families and with all participating family members.

Restructuring Phase

Goals derived during the Joining & Assessment Phase provide the structure for guiding the family to negotiate tasks associated with daily living. Repetitive transactional patterns, which develop over time into 'rules' of interacting, drive how the family handles the tasks associated with daily living. FCT interventions target shifting the repetitive interaction patterns that make up the structure of the family. FCT practitioners continue to assess for trauma influences and incorporate trauma processing into interventions. Throughout this phase, the family engages in experiential activities where they are practicing new skills with the FCT practitioner present. Between session homework is assigned at the end of each session for families to practice their skills then the experiences are shared in their next session. The ongoing emphasis on trying something new and practicing it repeatedly creates new patterns of interaction that better align with the family's target treatment goals.

Valuing Change Phase

The Valuing Change Phase is a critical and distinct component of FCT where the family learns to recognize and value their new patterns of interacting. They discover that their changed behaviors have value well beyond specific situations and can be applied to future circumstances. FCT posits that all families have inherent value. All families reach out for assistance and support at challenging times in their lives. FCT practitioners partner with families to recognize their core strengths and values and to acknowledge that the underlying intent of previous interactions was based on their values but not always conveyed as intended.

In this phase, families also learn about and experience the 'power of giving'. Families learn to give to others as a method for discovering their inherent worth and dignity. In the Valuing Change Phase, FCT practitioners aid the family in identifying and honoring their intrinsic beliefs and values. Sustainable change occurs when behavioral changes align with core values and are seen as necessary by the family.

*Family Assessment Device, based on the McMaster Model of Family Functioning (MMFF). Epstein, N.B. et al (1983). The McMaster family assessment device. Journal of marital and Family Therapy. 9, (2), 171-180.
** Care Process Model-Pediatric Trauma Screener. https://utahpips.org/cpm

Part 2: The Family Centered Treatment Model

Components of the Model

Generalization Phase

A family that enters the Generalization Phase of treatment is no longer overwhelmed by the crises or the circumstances that lead to crises. They are handling them with their new skills and reporting the outcomes to their practitioner. The practitioner's approach becomes less central in the process and shifts to a supportive and validating stance. The families prepare for predictable and unpredictable upcoming life events. FCT works with the family to determine the timing of closure using an analytical process to evaluate the changes that have occurred and the family's ability to use the strategies autonomously.

What Makes Family Centered Treatment Unique?

Distinctive to Family Centered Treatment is that it was largely developed by practitioners for inclusion in the behavioral and mental health array of services. Family and practitioners' feedback, along with research findings, allow for innovation and up-to-date practices that adjust to meet families' needs in the current world. FCT is a systemic process of looking beyond an identified family member, learning the family's unique dynamics, exploring intergenerational and systemic influences, incorporating all collaterals and stakeholders involved in the family's life, and integrating cultural themes into the process. For over 30 years, FCT has been advanced by these insights to bring a collective knowledge of 'what works and what does not work' to deliver family-driven positive outcomes.

Traditionally, evidenced-based models were designed in a controlled setting and then field-tested. Family Centered Treatment was designed from experience, then refined into a researched evidence-based model, a truly remarkable grassroots accomplishment.

The Valuing Change Phase of treatment is perhaps the most significant distinctive feature. Instead of closing services once a family demonstrates basic compliance to new behaviors, FCT sees this as a crucial turning point and involves broadening treatment beyond conformity and compliance. This phase, while at times challenging for families, is the critical link of bridging newly learned skills to match the family's culture and value system to a point where the family develops pride in their family unit, embraces how their dynamics were shaped, and gains confidence in applying the new skills across a variety of situations.

In addition, FCT stands out as a unique model in its 'parallel process' where all FCT leadership positions at FCT licensed organizations are required to obtain certification for their identified implementation roles parallel to how FCT frontline practitioners must obtain certification to deliver the model.

Similar to how FCT's focus is on treating the family as opposed to one individual, the implementation of FCT focuses on partnering with the licensed organizations to align the FCT mission and values with those of the organization.

Part 2: The Family Centered Treatment Model

Complex Trauma Treatment Inclusion

Since elements of past traumas including historical and generational patterns can be discovered at varying points of treatment, FCT practitioners are trained to identify potential signs and symptoms of trauma at any point in the treatment process. Trauma Treatment is not a prescribed phase of treatment within the FCT model because trauma is not a stand-alone experience. Therefore, trauma-informed protocols are incorporated when trauma is discovered. The FCT Trauma Treatment training and curriculum was enhanced last year through the adoption of the Care Process Model for Pediatric Trauma Stress (CPM-PTS) through a new partnership with the Pediatric Integrated Post-Trauma Services (PIPS) team at the University of Utah. The Family Centered Evaluation fidelity component along with the routine administration of the CPM-PTS provide means of identifying individual, family and generational patterns of trauma as well as screening of potential suicidal thoughts and ideations. Through years of collective research, FCT has determined that some form of systemic trauma to one or more individuals has been identified in more than 70% of referred FCT cases.

The FCT initial evaluation components are designed to enable the family to experience their story in a visual, participatory, and often pleasurable process. During these assessment activities, opportunities are provided for sharing how past experiences have and are impacting current functioning, which lead to reframing and rewriting trauma narratives. FCT trauma treatment focuses on addressing the systemic dynamics of trauma on the family system, not just an individual. In identifying how individual traumas and emotional blocks are impacting the family system, FCT looks to address underlying feelings, attachment needs, and interactional patterns of the family system. Family members learn how trauma experiences shaped their way of interacting with each other and when trauma is not addressed, dysfunctional patterns of interaction are likely to develop or remain ongoing. FCT practitioners can specifically create solutions for managing trauma that has impacted individual and family functioning. When family members identify their traumas, learn the function of underlying behaviors, attempt new ways of interacting, and share new positive experiences with each other, the family is working in unison to accomplish a shared goal.

Care Process Model-Pediatric Trauma Screener. https://utahpips.org/cpm

Part 2: The Family Centered Treatment Model

Results and Outcomes

Data collection, analysis, and outcomes are what drive FCT's advancement. When agencies are licensed as a provider of FCT, the Family Centered Treatment Foundation provides research and program evaluation related to the model in conjunction with numerous managed care organizations and state systems of care.

Outcomes are tracked monthly for each site and include fidelity to components, adherence to treatment intensity, demographic information, and clinical outcome measures as well as implementation science measures. The FCT Foundation has compiled FCT data at the national level for nearly 20 years. In 2022 we will launch Qualtrics, an innovative electronic data management system, to allow for the analysis of real-time data and reporting.

COVID-19 presented significant challenges in the provision of services typically provided in the home. Many FCT providers adopted telehealth utilization for the provision of FCT, which one may assume would negatively impact a service traditionally dependent on the full engagement of families in their home environments into experiential practice. Nevertheless, families who were fully engaged in FCT during 2020 had treatment outcomes that were virtually unchanged from those of previous years.

2021	National
Persons Served	3082
Family Members Served	6532

FCT Research

Family Centered Treatment has and is participating in numerous major national studies designed to meet the criteria necessary for designation of FCT as an evidence-based practice. Three national studies have concluded with results receiving publication in nationally recognized peer-reviewed publications. These publications include RAND's findings to the US Department of Health and Human Services in the publication *Evidence-Based Practices for Children Exposed to Violence: A Selection from Federal Databases,* and publications in *OJJDP Journal of Juvenile Justice, Research on Social Work Practice*, and *Children and Youth Services Review*. Additionally, FCT has been published in a report through the University of Maryland School of Social Work; *Youth Outcomes Following Family Centered Treatment® in Maryland.*

Currently, the Family Centered Treatment model is part of a large-scale randomized controlled trial research study in North Carolina. This study, conducted by the Duke University Center for Child and Family Policy (sponsored and funded by The Duke Endowment), is methodologically designed at the highest levels of scientific rigor to determine FCT efficacy.

A research project initiated by researchers at the University of Maryland School of Social Work proposes to examine the effects of FCT on youth permanency and well-being outcomes using a quasi-experimental design with a comparison group receiving probation services-as-usual. This study is focusing on a juvenile justice population in Maryland, including an identification and analysis of cross-over youth.

A new research project initiated by researchers at Chapin Hall will examine the impact of FCT on child permanency and well-being in Nebraska's child welfare population. Permanency, behavioral, and trauma symptomology outcomes will be compared to children whose families receive services as usual.

Part 2: The Family Centered Treatment Model

Results and Outcomes

Independent Study Findings

In its first major published study, researchers examined the outcomes and cost savings from a program which diverted over 2,000 adjudicated youth from out-of-home services to FCT services. The youth examined were followed for at least one-year post-treatment and actual treatment costs of FCT were determined.

The results of this study were reported in the Journal of Juvenile Justice in 2012, which concluded: In the first year following treatment, youth receiving FCT significantly reduced the frequency of their offenses and adjudications. These findings were sustained 2 years post-treatment. The results were consistent across groups in the first year following treatment. In the second year following treatment, however, FCT youth exhibited a much greater decline than the comparison group in both the average frequency of adjudications and the proportion of youth with adjudicated offenses. Moreover, in the first year following treatment, FCT reduced the average frequency of residential placements, days in pending placements, and days in community detentions relative to those of the comparison group. Had these youth been placed in Group Homes or Therapeutic Group Homes, treatment costs would have been significantly higher. In this study, results showed the cost of treatment per youth served through FCT saved the state $27,916 per youth in Group Homes and $25,433 per youth for Therapeutic Group Homes. Every dollar spent on FCT saved the state $3.29 in residential placement costs. In total, the FCT model saved the state $12.3 million from 2003-2007 during the intervention period. This analysis understates the total savings to the state from the FCT intervention, as costs due to reduced placements during the follow-up period were not calculated.

**EVERY DOLLAR SPENT ON FCT
SAVED STATE FUNDING $3.29**

Family Centered Treatment®   Residential Placement Costs

In response to reviewers at the Title IV-E Prevention Services Clearinghouse, the above study was revised to examine impacts on all out of home placements combined and to control for minor differences in baseline characteristics between the two groups. The findings show that youth receiving group home services were twice as likely as those receiving FCT to experience another out of home placement in the year following discharge from services. These results are published on the FCTF and Nebraska DHHS websites as *A Quasi-experimental Evaluation of Family Centered Treatment® in the Maryland Department of Juvenile Services Community Based Non-residential Program: Child Permanency. R. 2021*

Results and Outcomes

In 2015, a second major study was completed by researchers at the University of Maryland School of Social Work. Their report titled *Youth Outcome Following Family Centered Treatment® In Maryland* established that initial intervention costs and total placement costs over the study period were significantly less for FCT than for group home youth. The FCT model saved the state of Maryland $129.8 million from 2008-2015.

The report concluded that the initial intervention cost for FCT as compared with group home placement was less costly by $30,170 per youth, on average. This was attributed to a combination of youth having longer lengths of stay in group homes (201 days vs. 151 days for FCT) and the lower daily cost of Family Centered Treatment. In addition, post-admission placement costs were $41,730 less per youth, on average, for the FCT group compared to the group home group for the 12 months after the start of each intervention.

Relative to a statistically equivalent comparison group of youth who received group care, youth participating in FCT were significantly less likely to experience arrest resulting in conviction or sentences of incarceration in the criminal justice system. Re-adjudication rates were relatively low and juvenile justice commitment rates were very low in both groups. Among a matched subsample of youth ages 16 and over at initiation of treatment, FCT participants were significantly less likely to experience adult arrest leading to conviction or a sentence of incarceration than youth served in group care. These findings were later published in Research on Social Work Practice.

FCT 5–Year Study
Cost Benefit Analysis

>$129,800,000

Savings to State/Taxpayers in Maryland
2008–2013
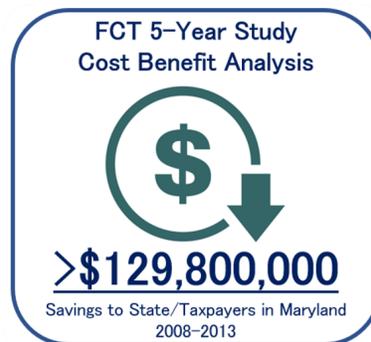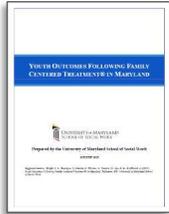
As part of the original Terms and Conditions of the Indiana 2012 IV-E Waiver, the Indiana University (IU) project team developed a sub-study which focused on the implementation and effectiveness of a specific treatment program. After considering options, IU developed a research design that evaluated the impact and effectiveness of FCT which was implemented with IV-E Waiver funds.

The effectiveness of the Family Centered Treatment (FCT) intervention was studied from January 1, 2015-December 31, 2015. All children referred for FCT received services as indicated via the model. Overall, of the 20,779 children within DCS between January 1, 2015, and December 31, 2015, 230 of those children not involved with the justice system received FCT. Using Propensity Score Matching, 187 children who received FCT were matched with 187 children who received services as usual.

Part 2: The Family Centered Treatment Model

Results and Outcomes
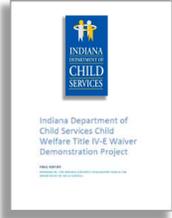
Overall, children and families who participate in FCT fared better than children and families who did not participate in FCT. Children who participated in FCT had better outcomes associated with their safety, permanency goals, and well-being. Children who participated in FCT were more likely to remain in-home during their involvement with social services, as well as be reunited with their family in a shorter timeframe and more likely to be ranked as 'conditionally safe' and 'safe'. FCT youths' family functioning climbed at a statistically significantly higher rate than non-FCT youth over time.

Of the 14 Safety, Permanency, Well-being & Family Functioning findings, 12 of 14 (86%) demonstrated favorable results for children receiving FCT. Additionally, 6 of 14 (43%) Safety, Permanency, Well-being & Family Functioning findings were statistically significant in favor of children who participated in Family Centered Treatment.

In response to reviewers, the above report was revised and select outcomes published in *Children and Youth Services Review*. The results show youth receiving FCT spent significantly less time – over two months – in child welfare services, reaching permanency more quickly than children who did not receive FCT.

FCT is categorized as a 'Family Stabilization Program' with 'High' Child Welfare Relevance. The mission of the California Evidence-Based Clearinghouse for Child Welfare (CEBC) is to advance the effective implementation of evidence-based practices for children and families involved with the child welfare system.

In 2019, FCT was approved as a Well-Supported model for use by states as part of the Family First Act Independent Systematic Review to claim for Transitional Payments.

Full reports, citations, and links can be found at: Publications, Studies & Reports — Family Centered Treatment

Model Implementation: Overview

FCTF implementation is rooted in the tenants of Implementation Science and applied in a structured and dynamic manner. The level of structure and support is calibrated with the organization's specific needs. For example, during initial implementation the FCT Foundation provides a high level of support, accountability and structure. FCT Foundation staff work intensively with new providers and titrate down as they build the necessary infrastructure and develop staff to assume FCT specific tasks and responsibilities. Interestingly, this also mirrors the clinical approach of creating ownership with the families who participate in FCT. This approach is coupled with the ongoing assessment of 'implementation drivers' and multiple levels of certification for practitioners and leadership. Through equal attention to the implementation process and clinical process FCT organizations achieve quality and sustainable programs.

**Implementation Process**   **Clinical Process**
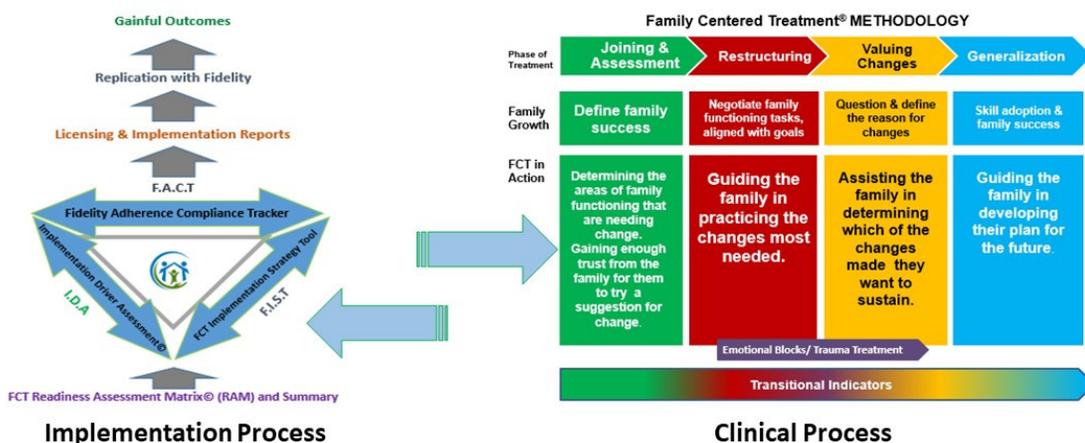
The FCT Foundation partners with licensed FCT organizations to implement FCT with integrity while also adhering to the specific strengths and needs of the organization, community, population served and stakeholders. In contrast to many other EBPs, practitioner training is only one, albeit important, facet to the implementation process. FCT implementation includes many other components including (but not limited to):

- Didactic, skill labs and field-based training and coaching
- Supervisor certification
- Situational Leadership training for all levels of leadership
- QA/data collection and utilization
- Developing high performing teams
- Stakeholder/community engagement
- Work with organization leadership to adjust operations/systems to support the model
- Recruitment and retention
- Collaboration with local and state entities to develop model supporting policies and practices
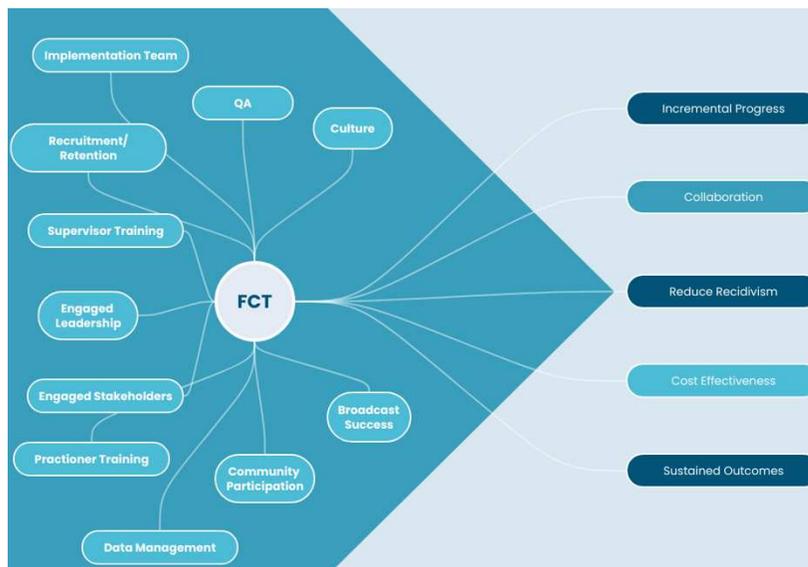
Model Implementation: Readiness Assessment and Active Implementation

Current advancements in the FCT implementation process focus on a developmental and dynamic approach, tuning implementation supports to the immediate needs of the organization.
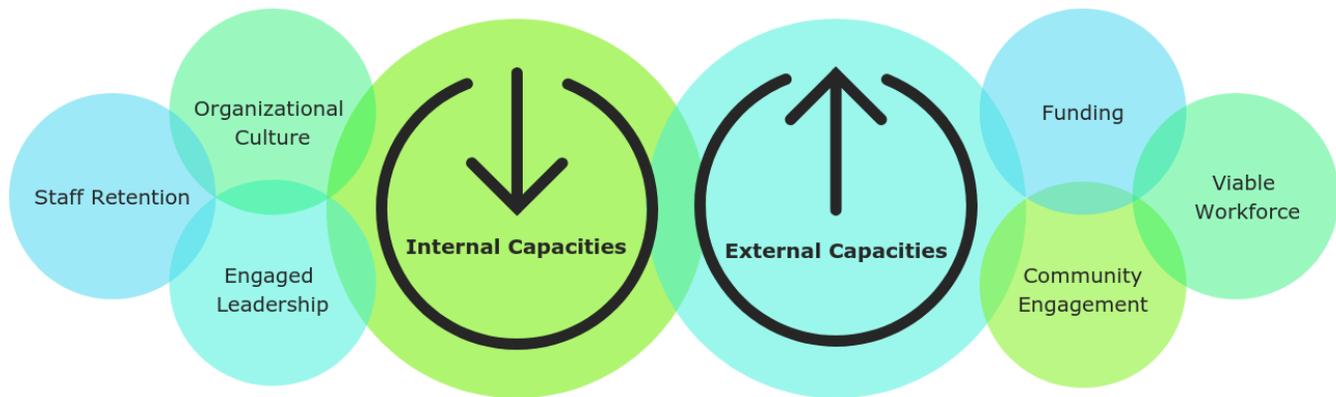
Readiness Assessment

FCT Implementation starts with a comprehensive Readiness Assessment facilitated by the FCT Foundation and completed in collaboration with the prospective organization. The readiness assessment evaluates the organization's internal and external capacities to implement the components necessary for the installation and development of a sustainable FCT program. The **Readiness Assessment Matrix© (RAM)** is a proprietary FCT tool used during the readiness assessment that quantifies the program's readiness across three categories: Implementation Drivers, Human Capital Factors and Return on Investment. The RAM illustrates and highlights the organization's relative strengths and areas of growth which provides FCT consultants with the information needed to develop the **Readiness Assessment Management Plan (RAMP).** The RAMP operationalizes the data from the RAM into concrete and organization specific early implementation goals and strategies to enable goal directed implementation from program launch.

Active Implementation

Upon completion of an agency's readiness assessment, active FCT implementation begins. FCT implementation includes several interrelated components including training, supervision, operations, fidelity adherence, research, and quality assurance. This methodology produces successful replication/ scale-up, quality services, consistent outcomes and sustainability.

Multi-tiered FCT Certifications:

FCT Practitioners, Trainers and Supervisors engage in didactic online training, in-person skills labs and field-based coaching to ensure that each individual demonstrates theoretical knowledge and skill competencies specific to their role in the FCT program. This is accomplished through a multi-tiered certification system (Levels 1-4) resulting in targeted skill transfer from the FCT Foundation to the FCT provider. As individual(s) achieve each successive certification, the program can certify their own staff and manage all aspects of the program.

Part 2: The Family Centered Treatment Model

Model Implementation: Readiness Assessment & Active Implementation

Active Implementation Continued:

Supervisor Certification: Supervisor specific didactic online training and field-based coaching ensure that supervisors demonstrate theoretical knowledge and hard skill competencies to enable a highly responsive and collaborative supervision process. In contrast to traditional supervision with a focus solely on case consultation, FCT supervisors learn to develop high performing, self-supervising practitioners.

Implementation Teams: One of the first tasks in early implementation is the development of an Implementation Team that includes FCT provider leadership, community stakeholders, and FCT Foundation staff. Implementation Teams participate in goal driven consultation meetings at a frequency determined by the organization's Stage of Implementation. The Implementation Team is responsible for all facets of FCT implementation with the FCT provider taking increasing ownership as their program develops.

Team Development: FCT Practitioner Teams are the heart of a FCT program and offer a novel approach to program management. Peer supervision is a fundamental component of a FCT Team and a non-traditional management approach. Through learning the peer supervision process, teams take responsibility for clinical consults, performance improvement, vicarious trauma, quality assurance, recruitment and other processes that are traditionally managed by organization leadership. Development of high performing teams results in practitioner ownership, quality service provision, practitioner growth and retention.

Quality Assurance and Improvement:
The FCT Foundation equips providers with a streamlined methodology for continuous quality improvement. The FCT Foundation works with an organization's existing QA/QI department to tailor the process to FCT. The recent implementation of Qualtrics for data management and utilization will provide further refinement to the process. Data from performances assessments, fidelity adherence, implementation assessments, training, research and outcome data collection and utilization are collected and utilized via multiple interlocking feedback loops.

Situational Leadership: Leadership development via Situational Leadership training and implementation to equip all FCT leaders with the skills to develop practitioners and supervisors to their fullest competency and commitment.

Part 2: The Family Centered Treatment Model

Model Implementation: Implementation Tools

The **Fidelity Adherence Compliance Tracker (FACT)** is a functional QA/QI tool that collects FCT clinical data to ensure fidelity adherence and clinical integrity. The collection and review of this data is intended to assist an organization and FCTF in tracking clinical performance, identifying strengths/areas of growth and identifying patterns to target as part of ongoing quality improvement cycles.

The **Implementation Driver Assessment Tool (IDA)** is used to assess the installation of FCT implementation drivers over time with the goal of achieving full implementation. Similar to the FACT, the IDA provides insight into strengths/areas of growth from an implementation perspective and is used to develop goals and strategies to achieve full implementation.

The **FCT Implementation Tool (FIT)** is an evolving document allowing the Implementation Team to develop concrete, practical and measurable goals and strategies to address areas of growth identified in the IDA. The program weaves these strategies into their operations and monitors progress during weekly implementation consults.

The **Licensure and Implementation Report (LIR)** serves as an annual summary of FCT implementation for the organization. This report examines the current Implementation Stage, the progression through the stages of implementation over time, developmental progression with the model, challenges and barriers hindering full implementation and assessment of performance measures and outcomes.

Gainful Outcomes

Replication with Fidelity

Licensing & Implementation Reports

F.A.C.T
Fidelity Adherence Compliance Tracker

Implementation Driver Assessment©

I.D.A

FCT Implementation-strategy Tool

F.I.T

FCT Readiness Assessment Matrix© (RAM) and Summary
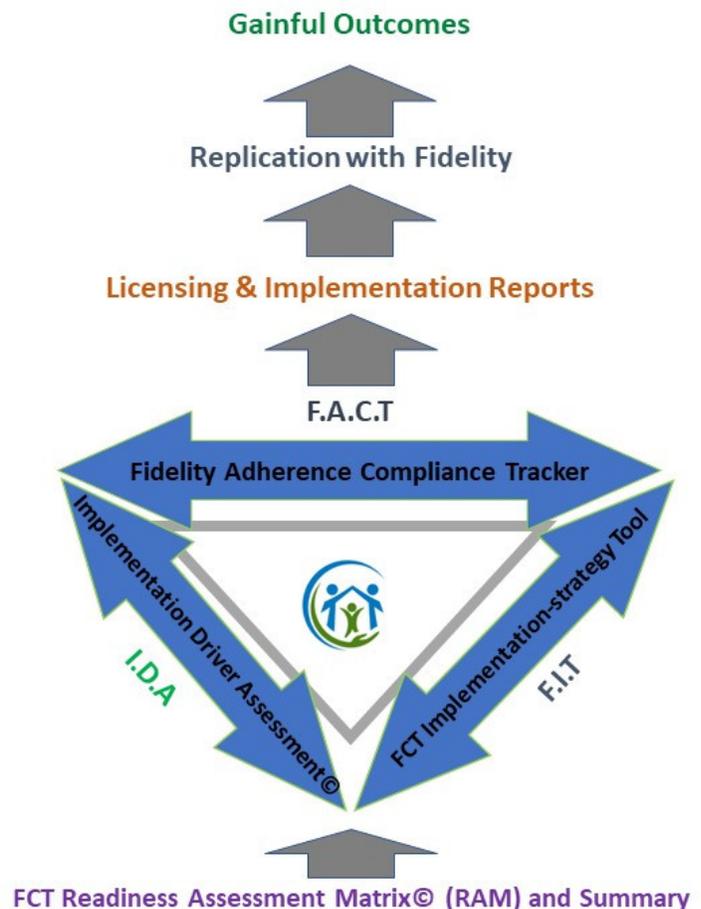
Part 2: The Family Centered Treatment Model

Model Implementation: Workforce Development

As with virtually all industries, the coronavirus pandemic and the tide of social change resulted in a seismic shift in the FCT workforce. As in previous times when the FCT community needed to shift in response to macro-system challenges, FCT providers led the way in adapting to this new reality. Here are a few ways in which the FCT community is responding to these challenges.

Diversity, Equity and Inclusion: The FCT Foundation and providers are making genuine and intentional efforts to make the model and organizations work for everyone. The FCT Foundation added DEI initiatives to their strategic plan, wove DEI into every committee and team process and made progress in including the voices

INCLUSION
Thoughts, ideas and perspectives of all individuals matter

Over saturation of similarity, homogeneous culture, and simplified points of view

The dominant group or ideology is deferred to for decision making, opportunities and promotions

BELONGING
An org that engages full potential of the individual, where innovation thrives, and views, beliefs and values are integrated

EQUITY
Constantly and consistently recognizing and redistributing power

Culture assimilation results in disengagement and low retention

DIVERSITY
Multiple identities represented in an organization

https://eventgarde.com/services/diversity-equity-and-inclusion

of providers, stakeholders and persons served in the ongoing development of the model.

Solution Hub: As providers implemented solutions both large (developing FCT specific internship programs with universities) and small (creativity in how to retain practitioners), the FCT Foundation served as an innovation and information hub, collecting, and disseminating innovations across the FCT network.

Reinforcement of Situational Leadership: Situational Leadership training is a core component of FCT supervisor training. The workforce crisis clearly demonstrates the relevancy of developing FCT staff to their highest level of competency and commitment resulting in increased performance and job satisfaction.

Recruitment and Retention Collaborative: The FCT Foundation initiated a Recruitment and Retention Collaborative bringing together organization leadership from human resources and operations to share ideas and generate new solutions.

State and National Advocacy: Many states allow for both licensed and bachelor level staff to provide FCT. The original study that demonstrated FCT's effectiveness* was conducted using a blend of both licensed and bachelor level practitioners, each of whom were proven effective. The FCT Foundation is actively partnering with providers and state/local governmental entities to advocate for the inclusion of bachelor level staff across all states. These efforts will expand the pool of qualified FCT practitioners that historically demonstrate quality outcomes and long-term retention.
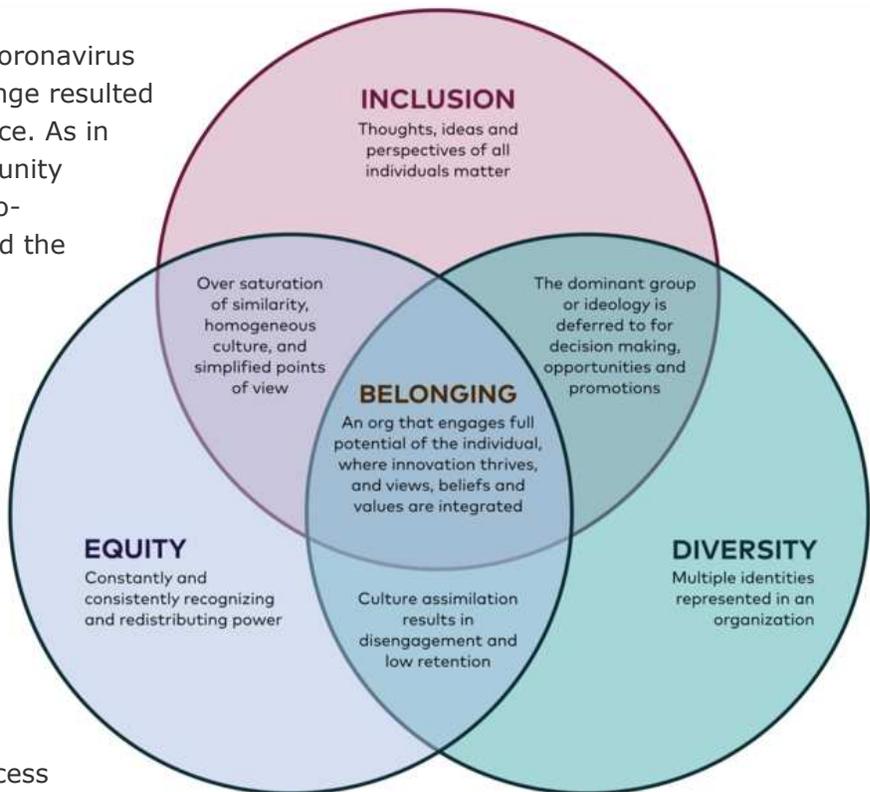
*Sullivan, Melonie B. Department of Research, FamiliFirst, Inc.; Bennear, Lori Snyder Department of Environmental Economics and Policy, Nicholas School of the Environment and Earth Sciences, Duke University; Honess, Karen Independent Contractor, FamiliFirst, Inc.; Painter, Jr., William E., Department of Organizational Development, Institute for Family Centered Services; Wood, Timothy J. Department of Research, FamiliFirst, Inc. Family Centered Treatment®—An Alternative to Residential Placements for Adjudicated Youth: Outcomes and Cost- Effectiveness. OJJDP Journal of Juvenile Justice, Volume 2, Issue 1, Fall 2012, Pages 25-37.

Part 2: The Family Centered Treatment Model

Model Implementation: How are FCT Costs Determined?

One of the first questions asked when prospective organizations are exploring FCT is "How much does it cost?" As part of the Readiness Assessment, the FCT Foundation submits a budget narrative to the prospective organization. Budget narratives are customized based on the program's size and scope. On average, implementation costs range from $2500-$3000 per month depending on the number of practitioners and sites for initial implementation. Budget narratives include all costs associated with FCT implementation: training, data management, reporting, site visits, consultation time, assisting with marketing/outreach, onsite travel, etc. Many EBPs use a learning collaborative approach in which training is the sole or primary implementation component. As previously mentioned, FCT implementation is multi-faceted, comprehensive, and continuous. Despite the robust support offered by the FCT implementation process, FCT is more cost effective compared to most models. FCT Foundation's multi-tiered implementation and train-the-trainer processes develop programs toward self-sufficiency thereby reducing costs over time.

If a program stays relatively stable (e.g., turnover, etc.), they can expect fees to reduce by 10-15% in year 2, another 10%-15% in year 3, and then remain constant from that point on.

Path of Implementation
- Assess
- Build
- Tailor
- Sustain

Initial inquiries and information gathering

Submission of FCT Provider Application to the FCT Foundation

Determination of feasibility of Readiness Assessment inclusive of costs

Readiness Assessment

Review of scope and feasibility for Licensing by the FCT Foundation Board of Directors

Licensing

Launch and FCT Implementation

It is in the FCT Foundation's interest for programs to become self-sufficient as quickly as possible as we enable growth and expansion with new providers across the country. While rates are subject to market adjustment, it is important to note that the FCT Foundation is a 501(c)(3) charitable non-profit. Therefore, all associated revenue earned from the FCT model is directly reinvested into the advancement of the model.

Many prospective organizations inquire about caseload size and length of treatment as they prepare budgets for FCT implementation. Treatment intensity (the amount of direct clinical services) is a fundamental component of the model and the primary driver of caseload size. On average, families receive 5 hours and 2.5 contacts of direct clinical work per week and as a result, caseload size is typically 4-6 families. Treatment duration is variable due to multiple factors but on average total treatment duration is approximately 6-months. On average, a FCT practitioner will serve approximately 10-14 families per year.

Model Enhancements

Care Process Model-Pediatric Traumatic Stress Screener (CPM-PTS): In 2021 FCTF formally integrated this trauma screener into practice during FCT. This enhancement allows for routine assessment of trauma symptomology, suicidal ideation, and reporting of abuse/neglect.

Qualtrics: Qualtrics is a state-of-the-art web-based platform used by universities, organizations, and corporations around the world for data collection and utilization. We launched this platform in January 2022 to improve efficiency, reduce paperwork, and improve data analytics. FCT providers and the FCT Foundation have real-time access to information that is holistic and user-friendly.

Fidelity Documentation: Upgraded Fidelity Documents were a priority going into 2022. Feedback from frontline practitioners aided our Certification and Training Team in enhancing those tools. A new Family Giving Project Worksheet was also added to bring enhanced focus to that project and to provide prompts for formulating and organizing plans.

FCT Workbook: To bring more efficiency to the Family Assessment Device (FAD) and Care Process Model Pediatric Traumatic Stress Screener (CPM-PTS), we launched a combined Excel workbook where scores and rating averages for families are housed together.

FCT Roadmap: The FCT roadmap is a 5-step supportive tool where one enters the FCT Phase of Treatment, Area of Family Functioning, and Trauma Screener findings which then auto-calculate a Therapeutic Theme and then provide a link to a warehouse of family interventions and activities.

Eloomi: The FCT Wheels of Change training platform will transition to Eloomi, a Learning Management System packed with powerful features and chosen by over 500,000 users worldwide. Eloomi aligns with the give-back philosophy of FCT. Eloomi is made up of over 25 nationalities, all committed to ONE Eloomi culture, values, and diversity standards. They believe good business is about giving back. They have a strong focus on their corporate social responsibility effort with contributions to the Red Cross, alignment to the UN Global Compact Principles, and run on a green business model with zero travel.

Leadership Cohort: The Leadership Cohort is a monthly collaborative bringing together FCT Leadership from all FCT Licensed Organizations. Presenters are either from the FCT Foundation or are top leaders at the provider agencies. Topics focus on FCT supervision and oversight, model development and feedback, and useful tools to share across sites.

Let's Talk Series: 2021 initiated a monthly series open to all FCT personnel to discuss a topic of the month. The Series is hosted by Stephanie Glickman, FCTF Clinical Director, and has included topics such as Tweens, Shame vs. Guilt, Hormones, Nutrition & Behavior, as well as inviting guests from other national organizations focused on children and families.

FCT Why Under 5 Podcast: Also hosted by Stephanie Glickman, this podcast explores varying facets of FCT and the 'why' behind how we do the things we do in the model. Each episode is 5 minutes or less to make listening and learning quick and efficient.

Model Enhancements

Parent/Family Voice and Lived Expertise: A former FCT Parent joined our Development Committee and has been integral to bringing a recipient perspective to our model initiatives. Plans are also in place to integrate a prior youth recipient of services to our Trauma and Cultural Inclusion Team. Additionally, through our partnership with NCTSN, the FCT Foundation sponsored and participated in a featured webinar collaboration with Amnoni Myers, whose childhood experiences in foster care drive her commitment to help others realize their potential and break the cycles of generational poverty.

Diversity, Equity and Inclusion: The FCT Foundation continues to increase our Diversity, Equity, and Inclusion initiatives, not only within our workforce, but also for the families served. These encompass broadening how we continue to integrate each family's unique cultural constructs into their journey through the phases of the model. These include but are not limited to: language/terminology changes, clinical support tools, implementation support measures, trainings, and community outreach enhancements inclusive of social media platforms. August 2021 hosted the first of 3 trainings led by the Nebraska Indian Child Welfare Coalition. We have also adopted new partnerships with the Children's Trust Funds Alliance, the National Foster Parent Association, the National Family Support Network and others.

Grand Rounds: Weekly clinical Grand Rounds are offered to FCT Practitioners and Supervisors to discuss cases needing an added level of intervention support. The Foundation also offers scheduled case consultation for practitioners and supervisors with the Chair of the Development Committee.

FCT Foundation Committees and Teams

Model enhancement has launched the Foundation into adopting added formalized Committees and Teams. Parallel to our clinical process, we believe effective change is achieved through group work and systemic collaboration. Below are our Foundation Committees which require active Board Member representation as well as our Teams which are comprised of FCT Foundation staff, FCT Provider representatives, former FCT family members, and/or community stakeholders.

FCT Foundation Committees

Development Committee
Finance Committee
Fundraising Committee
Future Business Modeling Committee
Governance and HR Committee

FCT Foundation Teams

Conference Team
Duke Endowment/Randomized Control Trial Team
Executive Management Team
Implementation Science Team
Indiana Team
North Carolina Team
Prospective Organization and Readiness Team
Quality Assurance Team
Qualtrics Team
Research Team
Training and Certification Team
Trauma and Cultural Inclusion Team

Part 3: Advancements and Initiatives

NCTSN Collaboratives

The FCT Foundation's partnership with the National Child Traumatic Stress Network lends to ongoing collaboration with participants across the larger network in the form of monthly collaborative meetings. Representatives from the FCT Foundation are involved in the following groups:

Child Sexual Abuse
Complex Trauma
Implementation Summit Train-the-Trainer
Military and Veteran Families
Partnering with Youth and Families
Rural Practice
Secondary Traumatic Stress
Sexual Health Subcommittee
Steering Committee
Trauma and Substance Abuse

Demonstration Sites

FCT-Recovery: FCTR layers the evidence based, in-home treatment model of FCT, with sobriety support and interventions when there is substance misuse by a parent.

FCT Reunification: This demonstration site provides services to youth referred to FCT and placed in foster care simultaneously to decrease time in foster care, prepare the family for reunification and address issues that led to out of home placement.

FCT Family Engagement Services: Partnership between Managed Care Organizations, Psychiatric Residential Treatment Facilities (PRTF), and FCT Providers. Goals:
- Increasing family involvement while a child is placed at a PRTF
- Reducing the time in residential placement
- Provide families with a consistent treatment provider before, during and after a child's residential placement.

Randomized Control Trial Study sponsored by Duke Endowment: Reducing the Need for Out-of-Home Placements: A Randomized Controlled Trial to Examine the Effects of Family Centered Treatment on Well-Being Outcomes and Public Dollar Costs.

Target Demographics

FCT has shown efficacy with a diverse range of populations, family make-ups, and demographics throughout its history. Families with children 0-21, multigenerational families, kinship, and foster caregiver settings are just a few examples of the many types of families FCT serves annually. As we continue to innovate, it is important to note that service to families is not limited by age, caregiver demographics, clinical diagnoses, or other indicators that might limit and ability for FCT to serve.

Part 4: The FCT Provider Network and Community Impact

Where is Family Centered Treatment?

The Family Centered Treatment model is provided at 75 sites across 11 states. Additionally, the FCT Foundation partners with numerous state systems of care, managed care organizations and child welfare partners to fund implementation of the FCT model. The FCT Foundation is prominent at local, state, national and international conferences providing consultation and training of Family Centered Treatment. A complete listing of current FCT Licensed Organizations can be found on our website. The FCT Foundation is based in Charlotte, NC with its Administrative Office in Great Falls, VA.
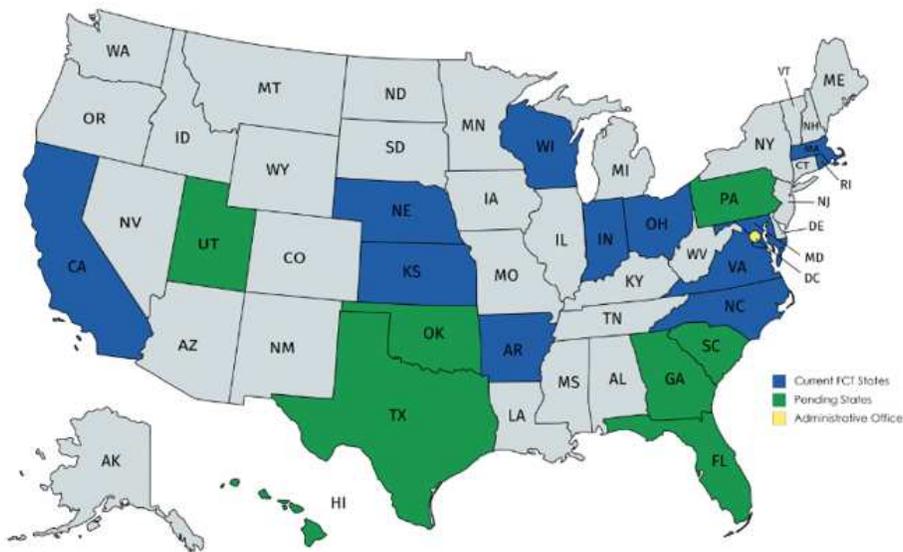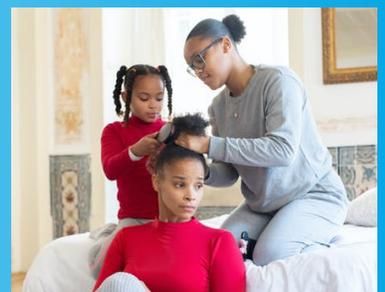

> " During a closing session of FCT, we had a family BBQ and all three adults talked about the progress made during FCT. The parents made a promise to themselves and their children, "don't look back, we're not going that way". "

Part 4: The FCT Provider Network and Community Impact

Recognitions and Affiliations

Listings and Clearinghouses

- The California Evidence-Based Clearinghouse for Child Welfare
- Title IV-E Prevention Services Clearinghouse
- SAMHSA's National Childhood Traumatic Stress Network
- OJJDP Model Programs Guide - CrimeSolutions.Gov
- SAMHSA's National Registry for Evidence-based Programs and Practices
- PEW Charitable Trusts Results First Clearinghouse Database
- Quality Improvement Center for Adoption & Guardianship Support and Preservation
- Clearinghouse for Military Family Readiness at Penn State

Research Funding and Collaborations

- The Duke Endowment of the Carolinas
- The Duke Center for Child and Family Policy
- Professional Consulting Group - National Research Consultant
- Chapin Hall/Nebraska DHHS
- University of Maryland School of Social Work
- Indiana University School of Social Work/Indiana Department of Child Services
- University of Arkansas School of Medicine/Arkansas DHS

Training and Education Exchanges

- Texas Alliance of Children and Family Services
- Nebraska Indian Child Welfare Coalition
- Creating a Family
- Christ's Haven for Children
- North Carolina National Association of Social Workers Learning Institute
- National Foster Parent Association

Part 4: The FCT Provider Network and Community Impact

Recognitions and Affiliations

University Partners

The FCT Foundation has been privileged to work with numerous universities in the advancement of research around the FCT model. Quality research with rigorous design has been instrumental in the advancement of understanding what works with families. Currently, the Duke University Center for Child and Family Policy as well as the Duke Center for Health Policy are conducting the first randomized control trial study with FCT. A new partnership with the University of North Carolina-Charlotte has launched intern field-placement opportunities for students in the Department of Communications Studies and their School of Social Work.

Affiliates and Partners

Benefits of Becoming a FCT Provider

FCT can have a positive impact on critical business elements such as: strengthening the organization's position in the state and community, marketing and collateral relations, clinical goal planning and documentation, team effectiveness and staff retention, utilization review of necessity for services, hiring motivated practitioners, and improving data collection, research, and distribution of data for your agency. These factors make FCT a progressive, encompassing model for agencies ready to implement an evidence-based model that has positive impacts for both the organization and families served.

Funding sources for FCT can be diverse and vary across states and communities. Common methods of funding include Medicaid, Title IV-E, state, local grant/contract awards, state budget allocations, and Federal grant funding. FCT can adapt to several reimbursement systems including fee-for-service, per diem rates, case rates, and shared risk/incentive models. Expansion of partnerships with private insurance companies is a primary initiative for the FCT Foundation in 2022.

- Ability to offer a unique Evidence Based Service option to better serve clients and families.
- Each organization receives a specific implementation and sustainability plan for use of the model to ensure long-term growth, stability and cost effectiveness.
- FCT is a proven way to maximize the efficient use of resources.
- Implementing FCT expands funding options through public/private grants; special federal, state, or local service funding categories; and partnerships.
- FCT providers become part of a national support network that allows consistency across borders regarding innovations, program development, networking and advocacy.
- Each new site that implements FCT strengthens the model. The origin of FCT is rooted in practice-based evidence. Practitioners, leadership and families served participate in the ongoing development of FCT providing each an opportunity to shape the model to meet the needs of today and tomorrow.
- FCT promotes broad entrance criteria with very limited exclusionary criteria thus enabling providers to serve a wide array of target populations.
- Structured but flexible implementation design is tailored to the needs of local communities and meshes with existing provider operations.

The application process is quick and easy. Click here to get started.
To learn more about becoming a FCT provider, contact Jon McDuffie, FCT Implementation Director at jon.mcduffie@familycenteredtreatment.org
828-301-4252

About the Family Centered Treatment Foundation

The Family Centered Treatment Foundation is a private non-profit incorporated organization devoted to the strengthening and preservation of families through research, training, and development. The Foundation owns Family Centered Treatment (FCT), an evidence based and well-supported trauma treatment model of home-based family therapy.

FCT's home-based treatment reduces the need for out-of-home placements. It has been refined based on research, experience and evidence of effectiveness. FCT is a cost effective means of stabilizing and reunifying families while cultivating hope through innovation.

www.FamilyCenteredTreatment.org